Department of Social and Health Services
&
Department of Health

First Steps Program
CONTINUOUS QUALITY IMPROVEMENT

FINAL REPORT
June 30, 2007

STERLING
ASSOCIATES, LLP.

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Executive Summary

Executive Summary

Background

- The First Steps program is a Medicaid program administered by the Department of Social and Health Services (DSHS) Health Recovery Services Administration (HRSA) with the assistance of the Department of Health (DOH) Maternal and Infant Health (MIH) program. First Steps services are provided by a network of contracted agencies in every county including community health nurses, community health workers, registered dietitians, behavioral health specialists, infant case managers and childbirth educators. Both public and private agencies including local health jurisdictions, community and migrant clinics, hospital-based programs, several tribes and other health social service and/or health agencies across Washington State have contracted to provide MSS/ICM services.
- The Maternity Support Services/Infant Case Management (MSS/ICM) Charting and Documentation Project (Documentation Project) began in 2004 to develop standardized First Steps forms to support statewide data collection and reporting and to improve service delivery. The new requirements were implemented in January 2006 with an intended goal to reassess them one year after implementation. In 2007, the Department of Health retained Sterling Associates, LLP, to assist in the review of the Documentation Project and to develop a Continuous Quality Improvement Model (CQI) to be used by First Steps for future program change endeavors.

Scope and Objectives

- After implementation of the new requirements, the provider community was asked to provide feedback. Providers raised concerns about the efficiency and effectiveness of the new forms. While significant activities were undertaken by DOH to engage service providers, the provider community felt it did not receive opportunities for adequate input into the redesign of the new requirements. Since the provider community is a vital partner with the state in delivering services to the First Steps customers, the state observed a need for a more formal process for outreach to the provider community.
- This report covers Sterling Associate's process to develop the First Steps CQI model by:
  - Assessing past and current efforts to obtain provider involvement with First Steps;
  - Identifying gaps and areas of improvement; and
  - Establishing a CQI framework and structure that can be used on an on-going basis to implement, manage, and monitor change.

Executive Summary (continued)

Post Implementation Review

- The First Steps Documentation Project provides a unique opportunity to assess how well a specific change to the program was implemented. Further, a post-implementation review (PIR) of the Documentation Project allows the state to identify lessons learned and apply them to future program change efforts. The results of the PIR were applied to development of the CQI model presented in this report.

  General Themes We Heard

  – Providers were asked to identify their challenges working with the First Steps program and with the Documentation Project. The themes we heard in focus group sessions and telephone interviews were very similar from one group to another. In addition, feedback DOH received prior to the start of the CQI project mirrored these themes as well.

    - Providers identified several problems with the new forms they would like to see addressed.
    - Training was not consistently provided.
    - Communication isn't necessarily provided or accessible by all providers.
    - Some providers lack access to technology or email.
    - First Steps state coordinator roles and responsibilities vary based on the positions within a particular agency.
    - Providers do not believe a formal "pilot" took place.
    - The First Steps program outcomes aren't clearly defined or communicated.
    - Providers stated that the new forms take significantly longer to complete, although the reimbursement has not increased to accommodate the increased time.
    - Some providers expressed concern that the purpose of the standardization was more of a "training tool" for a small core of providers who weren't providing complete charting information.

Executive Summary (continued)

Critical Success Factors

- Critical success factors are those elements that can impede and/or impact the success of any project or change that is implemented if not considered and incorporated into the process. In some situations, they may provide guidance to the project while in other situations, they may be elements that drive the project planning and design. Sterling Associates identified the critical success factors listed below based on our overall analysis of the First Steps program and the Documentation Project materials and information.
  1. A project plan and project foundation are established early in the project.
  2. Expectations are clearly defined at the beginning of the project, and as the project progresses and more becomes known or changed, expectations are refined as necessary.
  3. A Communication Strategy is defined and developed to match the project's requirements.
  4. Training is tailored to the project outcomes and expectations.
  5. The need for a pilot is calibrated against the extent of changes identified.

Findings and Gaps

- The following findings and gaps were identified:
  - The First Steps Project staff defined a substantially complete foundation to the project. However, additional activities including the formalization of a charter, communication strategy, budget, schedule and issues management process could have improved the project outcome.
  - Project staff and participant turnover resulted in a loss of critical project knowledge. A central repository of project documentation would have improved the retrieval and use of the critical project documents, especially for references in future improvement opportunities.
  - Many providers perceived that their comments were not taken seriously because they were unable to map their comments to the resulting forms. The state lacked a formal issue management process for documenting and responding to comments received. A formal issue/comment management process would have provided the structure staff needed to document a comment and develop a formal response to the sender. Without such a process, it is easy to lose control of the comments process which can lead to a loss of credibility. It can also increase the number of times particular decisions and situations are visited and decided.
  - DOH implemented an exception process that continues today. Exceptions to the forms could decrease DOH's objective to standardize practices and would increase difficulty in moving to an electronic system in the future.

Executive Summary (continued)

Findings and Gaps (Continued)

- Early project communications indicated that the new redesigned forms were not required. Several months prior to release of the new forms, some providers asked program management to mandate the new forms. Partly in response to these providers, program management decided to require use of the new forms. This change created some of the confusion around the new forms and increased frustration that the rules had changed without provider input or understanding. Managing expectations and communicating critical policy changes formally will allow the Department to gain credibility and integrity with the provider community.
- The Documentation Project established formal protocols for communicating project status using multiple methods and tools for communicating. However, the strategy lacked a validation process to ensure the communications were received and understood. The project would have benefited from a formal feedback process or method to ensure materials reached the right people, at the right time.
- One of the major objectives of the Documentation Project was to explore standardized data collection systems that would implement the charting requirements in an electronic record. Expectations regarding what that entailed may not have been shared broadly enough between the Department and provider communities. Although funding was not approved for the data warehouse solution, there has been no communication regarding next steps or future plans.
- Another major objective of the Documentation Project was to encourage providers to collect outcome data for monitoring the quality of client services provided and identifying areas of service improvement. It is unclear whether providers understood this as one of the objectives. A clear statement of the business case including the scope and objectives may have increased this understanding.
- Training for the new forms was offered by the Department, however, it was not required. Sweeping changes such as those brought about during the Documentation Project will need some sort of formalized training. A formal training plan defining the goals and objectives, training materials, a schedule, intended participants, and a training assessment is needed to communicate the impact of the change and prepare staff to implement the change successfully.
- Providers believe that a formal pilot period would have allowed a more robust review period for a small number of users to test the forms prior to full implementation.

Executive Summary (continued)

Continuous Quality Improvement (CQI) model

- Continuous Quality Improvement is a strategic approach to improve products, services or processes. It is an on-going effort to seek continuous, incremental improvement over time. The CQI model includes the following elements:
  - Plan for improvement or change,
  - Do implement the change,
  - Measure the impact of change,
  - Check the benefits, and
  - Act to expand to a broader implementation.
- It is important to understand that DOH followed a standard project model in implementing the Documentation Project. The underlying framework of the proposed CQI model is based upon this existing documentation model and includes refinements to build a collaborative process. The proposed CQI model is illustrated and explained on pages 36 to 52.

Improvement Opportunities

- Providers participating in the CQI focus groups and interviews were asked to identify and prioritize key challenges as well as solutions related to the Documentation Project and the First Steps Program.
  - **Networking Opportunities:** Providers would like to see First Steps Program host Regional Coordinators Meetings and Statewide Meetings.
  - **Training Plan:** Providers would like a training plan that explores the use of multiple methods of training including in-person, video conferencing, web-base, DVD, etc.
  - **Forms Improvement:** Providers expressed frustration with many of the forms; although we believe choosing one form for improvement would be a good example of a small, incremental step, as described in the CQI model. This incremental step would help DOH gain credibility and experience with the new model.

Executive Summary (continued)

Conclusion

- Throughout the focus group process, providers were reminded that changes identified would need to be considered in conjunction with available resources. DSHS and DOH may need to consider prioritization of improvement opportunities using criteria similar to the following:
  - Does the challenge/solution represent the majority of providers?
  - Will the challenge/solution provide a level of return on benefits for the providers and state based on the investment made?
  - Can the challenge/solution be addressed and supported with resources by the state?
  - Can the challenge/solution incorporate process steps from the proposed CQI model?
- Overall, the collective evidence that Sterling Associates' gathered shows that a good project framework was established by the state for the Documentation Project. However, provider feedback gathered in focus groups and interviews, support that not all of the state's efforts to collaboratively involve its providers were perceived as effective. Sterling Associates' believed the lack of formal processes may have created gaps in understanding between what had been implemented by the state and what was perceived by the providers. For example, evidence supports that the state made many attempts throughout the project to communicate project information through emails, meetings, work sessions, conference calls, and newsletters, to the provider community. Yet, providers still perceived a lack of information.
- Moving forward to build and support a collaborative environment for ongoing continuous quality improvement will require a strategy of commitment and involvement by both the state agency and the provider community. The state and providers share responsibility in building this collaboration early in any improvement process. For example, the state may establish the project scope, outcomes and expectations but without active participation, follow through and accountability by the provider, achieving successful change management will be hindered.
- The proposed CQI model provides a framework for project planning, implementation and management. The steps within the CQI model may or may not be needed in all projects. However, all steps within the CQI model should be considered for their relevancy during the planning stages. Some steps, such as developing a project plan, scope and timeline, will always be needed although the level of detail contained in them can vary depending on the complexity of the project. More complex projects will require more detailed planning. Further, the CQI model is designed to be transferable to any organization for any size of project.
- Before initiating a full CQI model on a complicated and over-arching change, we recommend using the model on a small scale to allow the organization to adjust and familiarize itself to the process.

Detailed Report

Introduction

- First Steps Program*
  - During the 1980s, women across Washington State faced increasing difficulty in accessing prenatal care. Rising malpractice premiums and low Medicaid reimbursement resulted in a shortage of obstetrical providers. Maternity care providers were increasingly reluctant to provide care to the growing number of Medicaid clients. Private practitioners, representatives of state agencies, public officials, and University of Washington faculty recognized this crisis in maternity care and formed the Access to Maternity Care Committee, sponsored by the Washington Chapter of the American College of Obstetricians and Gynecologists. This committee was instrumental in identifying the major cause of the maternity care crisis and in shaping the First Steps legislation.
  - The goal of the First Steps program, authorized by the Maternity Care Access Act of 1989, was to provide "maternity care necessary to ensure healthy birth outcomes for low-income families." The legislation called for the removal of unnecessary barriers to receiving prenatal care and provided for increased access to care and expanded Medicaid services for low-income pregnant women. [RCW 74.09.790]
  - The First Steps Program is a Medicaid program administered by the Department of Social and Health Services (DSHS) Health Recovery Services Administration (HRSA) with the assistance of the Department of Health (DOH) Maternal and Infant Health (MIH) program. DSHS is accountable to the federal Medicaid program and provides Medicaid funding for all First Steps services. Administration of the program is accomplished through an inter-local agreement which delegates authority by DSHS to DOH. First Steps services include Maternity Support Services (MSS) and Childbirth Education (CBE), both administered by DOH, and Infant Case Management (ICM), administered by DSHS. [RCW 74.09.800]
  - First Steps services are provided by a network of contracted agencies in every county including community health nurses, community health workers, registered dietitians, behavioral health specialists, infant case managers and childbirth educators. Both public and private agencies including local health jurisdictions, community and migrant clinics, hospital-based programs, several tribes and other health agencies across Washington State have contracted to provide MSS/ICM services.

From the DSHS website. http:/fortress.wa.gov/dshs/maa/firststeps/Provider Page/Provider Page.index.htm 4/11/2007 & *"The First Steps Program: 1989-1997, July 1999, Report Number 7.99" by Laurie Cawthon, M.D., M.P.H, and Elizabeth Salazar, B.S.,

Background

- First Steps Program* (continued)
  - Washington State's First Steps program provides support services and prenatal care to low-income pregnant women and infants. The First Steps program includes the following components:
    - Expanded Medicaid eligibility to 185% of the federal poverty level for pregnant/postpartum women and infants less than one year old,
    - Maternity Support Services during pregnancy and through two months postpartum,
    - Infant Case Management from three months postpartum up to one year postpartum for eligible families,
    - Increased reimbursement for maternity care providers, and
    - Designation of maternity care distressed areas to encourage community planning and enhancement of health care delivery systems for pregnant women and their infants.
  - The MSS/ICM portion of the First Steps Program provides enhanced support services to eligible pregnant women through the maternity cycle and for high risk infants and their families through the infant's first year. MSS/ICM services are designed to provide interventions as early in a pregnancy as possible to promote healthy pregnancy and positive birth and parenting outcomes. Enhanced First Steps services include:
    - Dietitian visits,
    - Behavioral health specialist visits,
    - Community health nursing,
    - Community health worker visits,
    - Childbirth education, and
    - Childcare services.

From the DSHS website. http:/fortress.wa.gov/dshs/maa/firststeps/Provider Page/Provider Page.index.htm 4/11/2007 & *"The First Steps Program: 1989-1997, July 1999, Report Number 7.99" by Laurie Cawthon, M.D., M.P.H, and Elizabeth Salazar, B.S.,

Background (continued)

- First Steps Program* (continued)
  - The First Steps program includes several supporting program goals to:
    - Decrease health disparities,
    - Reduce the number of unintended pregnancies,
    - Reduce the number of repeat pregnancies within two years of delivery,
    - Increase the initiation and duration of breastfeeding,
    - Reduce tobacco use during pregnancy and pediatric exposure to second-hand smoke,
    - Reduce risky behaviors associated with Sudden Infant Death Syndrome,
    - Improve pregnancy and post-pregnancy nutritional status through dietitian visits, and
    - Increase self-sufficiency of the mother and family unit.
  - Measures of improvement in pregnancy and parenting outcomes include:
    - An increase in early access and ongoing utilization of prenatal and newborn medical care,
    - A decrease in low birth weight babies,
    - A decline in infant mortality rates, and
    - A decline in maternal morbidity and mortality.

From the DSHS website. http:/fortress.wa.gov/dshs/maa/firststeps/Provider Page/Provider Page.index.htm 4/11/2007 & *"The First Steps Program: 1989-1997, July 1999, Report Number 7.99" by Laurie Cawthon, M.D., M.P.H, and Elizabeth Salazar, B.S.,

Scope of Review and Approach

- Following several years of development effort, the state implemented its new requirements for charting and documenting First Steps Maternity Support Services in January 2006. After implementation of the new requirements, the provider community raised concerns about the efficiency and effectiveness of the new forms. While significant activities were undertaken by DOH to engage service providers, the provider community felt it did not receive opportunities for adequate input into the redesign of the new requirements. Since the provider community is a vital partner with the state in delivering services to the First Steps customers, the state observed a need for a more formal process for outreach to the provider community. To increase success in future endeavors, the state retained Sterling Associates, LLP to develop a framework for a Continuous Quality Improvement (CQI) process that is more inclusive, allows partnering between the state and the providers, and supports a product development cycle that results in greater buy-in from participants.
- This report covers Sterling Associate's process to develop the First Steps CQI model by:
  - Assessing past and current efforts to obtain provider involvement with First Steps;
  - Identifying gaps and areas of improvement; and
  - Establishing a CQI framework and structure that can be used on an on-going basis to implement, manage, and monitor change.
- The First Steps Documentation Project provides a unique opportunity to assess how well a specific change to the program was implemented. Further, a post-implementation review (PIR) of the Documentation Project allows the state to identify lessons learned and apply them to future program change efforts. The results of the PIR were applied to development of the CQI model presented in this report. Researching past and current efforts helps avoid any processes that weren't successful or were perceived as unsuccessful, and highlights and enhances processes that are considered well done.
  - The first part of this report will focus on the post-implementation review of the Documentation Project. Subsequent sections will apply lessons learned during the PIR to the future CQI framework.

Scope of Review and Approach (continued)

- The CQI project began in early March 2007 with scheduled interviews with the First Steps state team members, a project kick-off presentation and interviews with the First Steps management team.
  - Interviews with the First Steps state team and management team helped define the parameters of the CQI project. The results of the discussion were used to frame discussions in provider focus groups and teleconference interviews.
  - Two major objectives were defined for the PIR process. The first was to understand how providers perceived the processes employed during the Documentation Project. This included understanding how providers were involved and what steps DOH and DSHS took to inform providers of progress and to communicate program changes. An adjunct objective was to train, mentor and develop DOH First Steps staff to implement future program changes through the CQI model.
    - At least one staff member from the First Steps state team was present as an observer in each of the focus groups and telephone interviews.
- Sterling Associates collaborated with the First Steps state team and the state coordinators to help identify a pool of participants for the focus groups. The state team identified providers who have:
  - A broad range of subject matter knowledge, experience and expertise;
  - A historical perspective about the First Steps program;
  - Participated in the previous documentation process and identified lessons learned;
  - A problem-solving attitude; or
  - Been actively engaged in responding to previous efforts.
    - It was also important to ensure that participants represented all of the First Steps disciplines including Community Health Nurse, Behavioral Health Specialists, Registered Dieticians, Community Health Workers, and Infant Case Managers. The groups were structured so that all types of agencies such as local health jurisdictions, hospitals/clinic based, social service agencies, and tribes were represented.

Scope of Review and Approach (continued)

- Focus groups were used to provide the most efficient and effective method to gather provider feedback. Focus groups offer an opportunity to elicit feedback from a cross section of the provider community. In summary:
  - Four focus group sessions were held in Olympia, Moses Lake, Spokane, and Everett;
  - 126 participants were invited, over 60 participants attended;
  - Four telephone interviews were conducted with the OMAHA project team, the Public Health Nursing Directors, and individual providers; and
  - Participants who were unable to attend the focus groups or any other stakeholders wanting to provide feedback were encouraged to call, write or email comments and examples to Sterling Associates.
    - Written comments were received from one provider.
- To provide additional context to the review, Sterling Associates reviewed background information including the DSHS and DOH websites, First Steps Newsletters, documents, and authorizing legislation and rules.
- During the implementation process, DSHS and DOH collected comments and feedback from providers about the new requirements. These comments were provided to Sterling Associates after completion of the focus groups. This information was used to validate focus group themes.

MSS/ICM Charting and Documentation Project – Post Implementation Review

- In the fall of 2003, the First Steps program underwent a major redesign to improve service delivery and contain costs. During the redesign, the Centers for Medicare and Medicaid asked the First Steps program to standardize services and develop ways to collect outcome based data.
- Standardized documentation has been a goal for the First Steps program since inception. The state believed standardized documentation would:
  - Better document core services and performance measures to be provided for all clients,
  - Improve monitoring and auditing processes by DOH/HRSA program managers and financial auditors during a time of increased scrutiny of Medicaid programs by the federal government,
  - Improve the ability of local First Steps agencies to quantify client progress and outcomes of maternal child health programs during budget short falls, and
  - Decrease the level of frustration by MSS/ICM clinicians caused by duplication of documenting services in client records.
- Standardized documentation was established to meet several program goals to:
  - Support First Steps program requirements for documentation;
  - Produce outcome data relevant to local First Steps agencies that meet state program, clinical care and management data needs;
  - Provide a vehicle for tracking clients statewide;
  - Provide services that are clinically relevant;
  - Promote quality care and standardized documentation of that care; and
  - Reduce the length and duplication of documentation and increase user friendliness, thus saving staff time.

MSS/ICM Charting and Documentation Project– Post Implementation Review (continued)

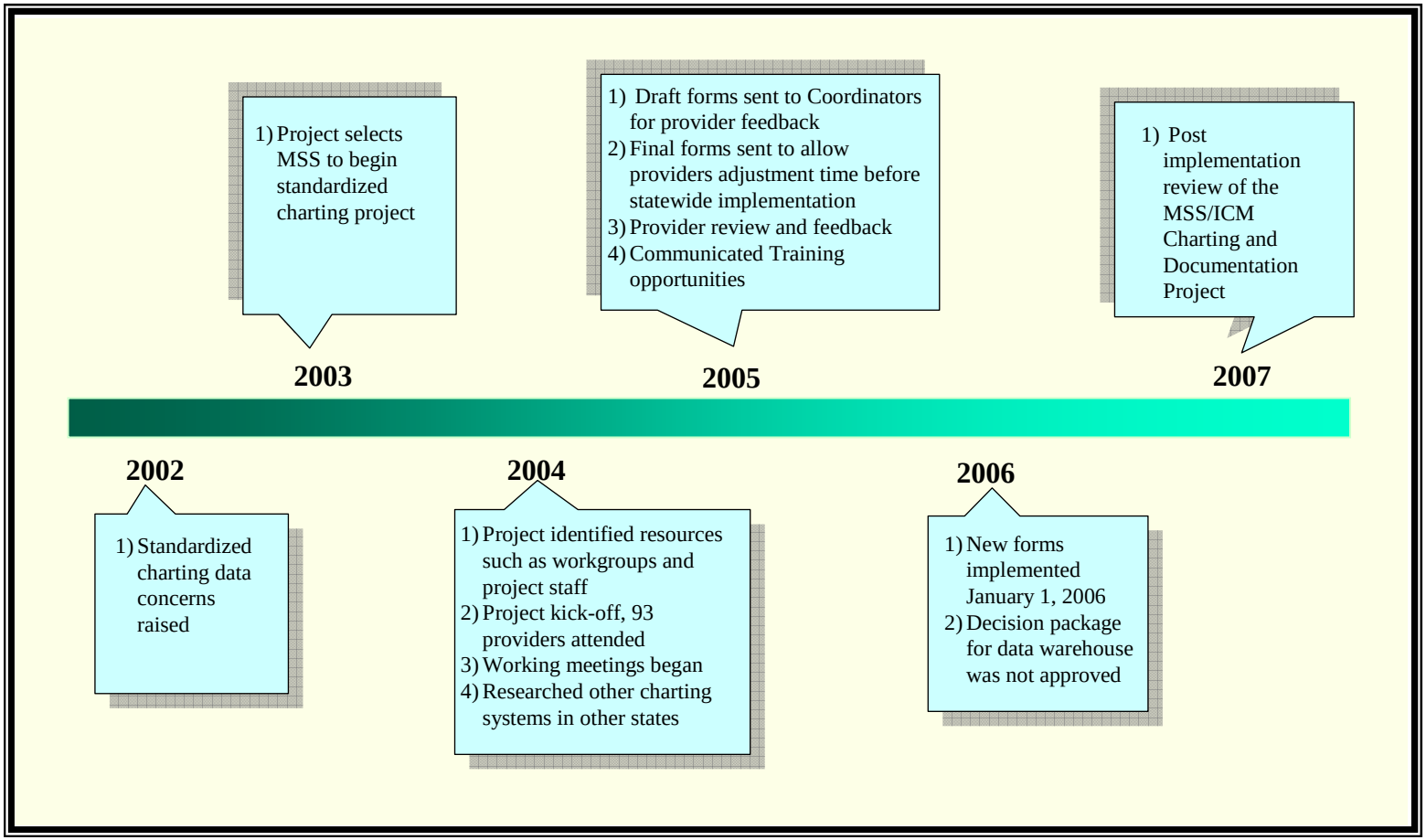
- DOH's approach to the Documentation Project focused on two key areas. The first was to conduct initial research in charting options and development of First Steps standardized forms. The local health jurisdictions chose the OMAHA system for documenting First Steps services. The OMAHA system provides a standardized taxonomy structure to document client needs and strengths, describe multidisciplinary practitioner interventions, and measure client outcomes in a simple, yet comprehensive manner. The decision to use OMAHA as the method for documenting First Steps services was not shared by all local agencies. Other local agencies had other charting systems that did not support OMAHA. The second area of focus concerned researching electronic charting systems used in other states and available on the market. The project assumed that newly created forms would be part of a technology/electronic solution. In general, the following high level activities occurred beginning in 2003. A graphical representation of the timeline is included on page 20 as Exhibit 1.
  - In 2003, the project team was formed and began work researching charting options. DOH worked with its federal partners in receiving approval for changing forms and documentation standards. A kick-off meeting was held with providers to explain the project scope and objectives. Additionally, DOH gathered examples of various forms already in use by providers.
  - The project continued in 2004 with the formation of various working committees (Advisory Committee, Work Committee, Information Only Group and other stakeholders) to elicit feedback and guide the formation of the new documentation process. Project resources were acquired to manage the project and facilitate committee meetings.
    - Considerable research with other state systems was completed during this timeframe and Washington's business requirements were compared to other systems to assess whether they would fit the state's needs.
    - Interviews regarding electronic system needs were completed with numerous provider representatives.
  - In early 2005, the state released the draft forms for review and comment. The forms were revised and finalized based on provider feedback. In August of 2005, the state First Steps coordinators were sent a complete packet with the final forms and instructions to be distributed to their providers. The required forms applied to new clients enrolled after January 1, 2006. However, providers were encouraged to use the new forms if they enhanced the services delivered to a previously enrolled client, and to gain familiarity with the forms prior to the statewide implementation date.

MSS/ICM Charting and Documentation Project– Post Implementation Review (continued)

- In May 2005, DSHS and DOH made a policy decision to require use of the forms versus the previous decision to make them voluntary. Several months prior to release of the new forms, some providers asked program management to mandate the new forms.
- On January 1, 2006, the new forms were implemented statewide. Providers were asked to use the forms for a year and provide feedback to DOH. DOH would then review the feedback and the forms would be revised as appropriate.
- This CQI process represents DOH's first efforts in revising the charting and documentation forms and processes. Information from this review will be used to determine steps for improving previously implemented forms and processes.

MSS/ICM Charting and Documentation Project – Post Implementation Review
(continued)

Project Timeline – Exhibit 1



General Themes of What We Heard

- Providers were asked to identify their challenges working with the First Steps program and with the Documentation Project. The themes we heard in focus group sessions and telephone interviews were very similar.
  - Although there were differences in specific examples or level of priority around the themes, overall, providers shared consistent concerns and issues in every focus group and discussion.
  - The focus of the discussion was dependent on the disciplines represented in the various focus groups (e.g., if the focus group contained more nurses, the conversations were more likely to be nursing centric versus social services centric).
  - There were variations in the themes influenced by the provider's position. Management generally focused their concerns around budgetary issues and maintaining productivity of services, and field staff generally focused on building client relationships and meeting the needs of clients.
- Providers identified several problems with the new forms they would like to see addressed.
  - Providers felt the new forms did not reflect the sample charts they had submitted for consideration.
  - Providers believed the new forms would be supported through an electronic charting system, which has not been funded or implemented to date.
  - Providers would like to see the forms reformatted (e.g., more writing space, more/different boxes, need to encompass more areas) to better meet their needs.
  - The same information is currently required in multiple places on the forms.
  - Many providers believe the forms are too nursing specific and do not sufficiently address behavioral or dietitian issues.
  - Some providers believe the "check box" format hinders the ability to apply their professional judgment to the case.
  - Providers feel the new forms put too much emphasis on completing the forms, rather than focusing on the client's need and providing services.

General Themes of What We Heard (continued)

- Training was not consistently provided.
  - Not all providers were aware that training was available on the new forms. As a result, many providers did not receive formal training which caused confusion about how to complete the forms. Further, this lack of formal training resulted in forms being utilized inconsistently from one agency to the next.
  - Training opportunities in general were not published or planned in advance. Providers requested that a calendar of training events be posted, so they can plan to send staff ahead of time.
  - Providers would like training that includes both discipline specific and general subjects.
  - In general, line staff believed training should be mandatory, while management believed it should not be mandatory.
  - Providers indicated a desire for different methods of training such as in person, web-based, DVD, and video conferencing. To the extent possible providers would like training to be incorporated into existing meetings.
  - Providers felt they should be compensated for attending any training required by the state.
- Communication is not necessarily provided or accessible by all providers.
  - There was general consensus that previously held statewide coordinator and regional staff meetings provided opportunities for training, receiving updates about service delivery, networking among peers, and discussions of best practices.
  - Providers stated that information is not consistently provided nor is there a central point of contact or reference place to ensure everyone has access to the same information or instructions.
  - Changes in policies, procedures, or other program services are difficult to locate as there are no alerts, highlights or links to specific changes.
  - The First Steps manual is not provided in a manageable format (i.e., provide hyperlinks to access specific references).
  - The new First Steps website is difficult to navigate and find changes without having to spend a lot of time searching for specific topics.

General Themes of What We Heard (continued)

- Not all providers have access to technology or email.
  - Providers who don't have email rely on their First Steps coordinators to provide information in printed form.
  - Providers who have email don't have ready access when working in the field.
  - Providers don't always consider email a priority.
- First Steps state coordinator roles and responsibilities vary based on their positions.
  - The level of communication seems to have a direct correlation with the role of the coordinator and availability of their time. For example, depending on the size and structure of the agency, some coordinators function as providers as well as coordinators. Particularly in some larger agencies, coordinators do not provide direct clients services and may have more available time to dedicate to coordinator duties. Distribution of materials may differ depending on the coordinator's time, availability or understanding of the needs of the line worker.
  - Coordinators stated they do not receive consistent information and directions as to what needs to be distributed uniformly and may need to decide independently which materials should be sent to whom.
- Providers do not believe a formal "pilot" took place.
  - Some providers believed the transition to the new forms was too abrupt. While there was a formal comment period, providers stated that a more formalized pilot would have better prepared them for the new forms.
  - Most providers in the focus groups believed there were few opportunities to identify problems and opportunities and correct them before the full implementation.
- The First Steps program outcomes are not clearly defined or communicated.
  - Because critical outcomes are not clearly defined, providers believe the state is requiring providers to collect data just in case the outcome will be tracked in the future. Providers expressed frustration that the state requires more data than is needed or used to track program outcomes. Further, providers believe the data currently requested is not being used to track outcomes or communicate the value of providing First Steps services.
- Providers stated that the new forms take significantly longer to complete, although the reimbursement has not increased to accommodate the increased time.
- Some providers expressed concern that the purpose of the standardization was more of a "training tool" for a small core of providers who weren't providing complete charting information.

Critical Success Factors

Critical success factors are those elements that can impede and/or impact the success of any project or change that is implemented if not considered and incorporated into the process. The critical success factors can vary in their use. In some situations, they may provide guidance to the project while in other situations, they may drive the project planning and design. The critical success factors should be reviewed with each change to assess and adjust accordingly. Sterling Associates identified the critical success factors listed below based on our overall analysis of the First Steps Documentation Project materials and information. In the following pages of this report, these critical success factors have been aligned to associated findings and gaps.

1. **A project plan and project foundation are established early in the project.**
   - Definition of project scope, objectives and goals should be developed and clearly articulated.
   - Project resources should be adequately matched to the approach.
   - Project leadership requirements are identified.
   - Project Controls (e.g., project plan and schedule, budget, issue management process, central repository) should be commensurate with project risks.
   - Feedback loops for questions and comments regarding documentation are established and implemented fully.
2. **Expectations are clearly defined at the beginning of the project, and as the project progresses and more becomes known or changed, expectations are refined as necessary.**
3. **A Communication Strategy is defined and developed to match project requirements.**
   - A map exists to align the type of communication needed by each stakeholder in the process.
4. **Training is tailored to the project outcomes and expectations.**
   - Training needs, training materials and a training schedule are defined in enough time for stakeholders to plan and participate.
   - Minimum levels of training are defined upfront.
   - Training resources are identified and available to support the requests.
5. **The need for a pilot is calibrated against the extent of changes identified.**
   - A controlled pilot is defined that includes a representative number of providers by type and agency.
   - The pilot scope, timeline and evaluation process are determined.
   - Findings from the pilot are published and used to improve the implementation process.

Findings and Gaps

This section highlights Sterling Associates' findings and gaps resulting from interviews, document reviews, observation and correspondence. There were also many examples and anecdotal information presented that helped form our responses. We have not attempted to include specific examples in this report, but are acknowledging the conditions and focusing on how improvements would inform the future CQI model for DOH.

Critical Success Factor #1 – A project plan and project foundation are established early in the project.

Findings:

- The First Steps Documentation Project staff defined a substantially complete foundation to the project.
  - Project resources such as a Steering Committee, Advisory Committee, Management Committee, and Stakeholder Group were identified early on in the project.
  - The committees included sufficient provider representation.
  - The project was staffed by a full-time project manager and two part-time contractors.
  - The First Steps State Team and the Steering Committee were interviewed early on in the project to identify project objectives, goals and program outcomes.
  - The project team requested feedback from providers on draft versions of the form.

Gaps:

- While much of the foundation was established, there were additional activities that would have improved the project planning activities. In general, the project did not formalize or document some critical project planning components.
  - A project charter would have helped document shared understandings about why the project was undertaken. While there was a shared vision from the state team, it did not carry into the provider community. The charter is a good tool for documenting the project goals, scope, expectations, project roles and responsibilities and governance hierarchy. Further, the charter provides the business case for making changes to a specific program.
  - A detailed project plan and schedule would have identified necessary tasks, timelines, and resources.
  - The state identified a project manager, but did not include a more robust analysis of resource needs.

Findings and Gaps (continued)

Critical Success Factor #1 – A project plan and project foundation are established early in the project. (continued)

Findings:

– During the duration of the project, some key staff members left the project taking with them critical knowledge about the project that was not always shared with others or documented. The small number of staff involved in the project complicated this issue further. As a result, the new staff could not provide historical information about the project beyond their involvement.

– Throughout our initial data gathering processes for the CQI project, we realized that fragments of information regarding the Documentation Project were available, but accessing evidence to support the findings proved more difficult than expected.

Gaps:

- Because the project lacked a documentation repository or other process to manage the vast number of comments and status, new staff were only knowledgeable about the pieces of the project they were involved in. The value of having a central location for project documents provides ease of retrieval and use of the documents, especially for reference in future improvement opportunities. Projects with multiple team members often use a SharePoint site to store, retrieve and manage project documents and information.

Findings:

– Many providers perceived that their comments were not taken seriously because they were unable to map their comments to the resulting forms. Communication from the project did not adequately address the process and criteria used in the design of the new forms. For example, providers didn't know how their sample charts were used. Instead, they feel their feedback went into a "black box." The state lacked a formal issue management process for documenting and responding to comments received. While it is likely the comments were not ignored completely, there was no project documentation available to determine whether comments received were in fact used in the final process.

Gaps:

- A formal issue management process would have provided the structure staff needed to document a comment and develop a formal response to the responder. Without such a process, it is easy to lose control of the comments process which can lead to a loss of credibility. It can also increase the number of times particular decisions and situations are visited and decided.

Findings and Gaps (continued)

Critical Success Factor #2 – Expectations are clearly defined at the beginning of the project, and as the project progresses and more becomes known or changed, expectations are refined as necessary.

Findings:

- The provider community represents a vast array of different services, systems and forms. The First Steps program acknowledged that providers may have compelling reasons for not using the new forms. For example, providers may have previously implemented or plan to implement forms and/or electronic systems that already adhere to the data requirements of the new forms. To address this issue, DOH implemented an exception process that determined if a provider's existing forms/systems met the data requirements and therefore, possibly excuse the provider from using the new forms.
- DOH established a set of criteria for evaluating whether a provider could be excepted from the new requirements.
  - The agency must present a compelling business reason for not adopting the documentation requirements. This must be beyond the difficulty of adopting new forms, or the agency must demonstrate a compelling business reason for delaying the implementation of the documentation requirements.
  - The agency has an adequate plan for complying with the requirements, including a timeline.
  - The agency proposes an acceptable alternative to adopting the forms or otherwise complying with the documentation requirements. For those First Steps agencies requesting to use other or altered forms, they must include copies of the proposed forms and a crosswalk to the required First Steps forms demonstrating where the required information is collected.
  - The exception request needed to be filed by the January 1, 2006, deadline.
- Evidence suggests that DOH's exception deadline of January 1, 2006, was not enforced, and in fact several exceptions continue to be requested. Approximately 30% of providers have received exception approval. Almost half of these exceptions were approved to support the local agency's transition to an electronic system and/or use of the OMAHA language.

Gaps:

- The extension of the exception process may inhibit providers from using and adjusting to the new forms. Some providers may choose to seek an exception and implement similar but non-standard forms. This exception process could undermine the state's initial goals of standardizing documentation in the field. Additionally, should the state move toward supporting electronic charting, the existence of multiple forms and formats used by providers could create difficulties in standardizing data fields in a system.

Findings and Gaps (continued)

Critical Success Factor #2 – Expectations are clearly defined at the beginning of the project, and as the project progresses and more becomes known or changed, expectations are refined as necessary. (continued)

Findings:

– Early project communications indicated that the new redesigned forms were not required. Several months prior to release of the new forms, some providers asked program management to mandate the new forms. Change in management direction from voluntary usage of the new forms to required usage by the providers created some of the confusion around the new forms and increased frustration that the rules had changed without provider input or understanding.

- The timing of the policy change may not have provided adequate time for providers to prepare their agency for adjustment to the new forms. For example, providers did not believe they had adequate time to plan for training or to formalize their review of the proposed new forms. In fact, some providers stated that they were not spending much time reviewing the forms because they planned to use internal forms instead.
- Most providers adapted their existing forms to their specific needs and processes and believed they had no compelling reason to change to the new forms when they were voluntary.
- Some of the larger provider agencies had already implemented or were transitioning to electronic charting systems and/or planning to use the OMAHA standardized language and format and assumed they would be granted exceptions to using the new forms.

Gaps:

- This change in policy came as a surprise to many of the provider organizations. Although the policy decision was influenced by provider feedback, we found little evidence to suggest that the policy change was carefully communicated to providers. Providers who participated in the focus groups and interviews, indicated they still do not understand why this change occurred. Managing expectations and communicating critical policy changes formally will allow the Department to gain credibility and integrity with the provider community. The notification delay of the policy change may have resulted in lost opportunities for providers to get more involved and informed around the planned changes for the new forms. Significant changes require adjustment periods to allow organizations to ensure staff readiness, staff training and policy and procedure updates have been planned for and implemented.

Findings and Gaps (continued)

Critical Success Factor #2 – Expectations are clearly defined at the beginning of the project, and as the project progresses and more becomes known or changed, expectations are refined as necessary. (continued)

Findings:

- One of the major objectives of the Documentation Project was to explore options to collect standardized data that would implement the charting requirements electronically. Expectations regarding what that entailed may not have been shared broadly enough between the Department and provider communities. DOH had intended to implement a standard data warehouse solution that could be used to capture data from the providers and develop reports using aggregated data. Providers believed DOH was developing a robust system that could be used by all providers to track and maintain clients case records electronically. These are two very different solutions and have resulted in the Department not meeting provider expectations.
  - In 2005, the First Steps Requirements Advisory Group was formed to begin defining the detailed design for the centralized data warehouse. With requirements defined, the Department submitted a budget decision package to fund the warehouse. However, in November 2006, the decision package failed to gain priority approval and was not sent forward with the agency budget.
- Many providers did not expect to implement their own systems and while some agencies, particularly larger agencies, are implementing electronic solutions, smaller providers believe they have been left out because they cannot afford to purchase and implement a system on their own.
- Providers believe the forms were developed to simulate an electronic system, and because of that, they are long, cumbersome and require too much duplication of effort and data entry. Providers expressed frustration and confusion regarding the lack of electronic charting as they believe it would resolve the redundancy and spacing issues encountered on the current paper forms.

Gaps:

- Providers did not receive closure to the electronic charting system decision and the funding request outcome. As a result, providers today do not see the value of providing the required data requirements. A structured issue management and communication strategy could have better prepared providers to understand decisions made. Even today, providers do not have information regarding the future of electronic charting by the state and as a result, providers who are implementing systems, may not meet the state's needs for gathering aggregate data for reporting outcomes.

Findings and Gaps (continued)

Critical Success Factor #2 – Expectations are clearly defined at the beginning of the project, and as the project progresses and more becomes known or changed, expectations are refined as necessary. (continued)

Findings:

– Another major objective of the Documentation Project was to encourage providers to collect outcome data for monitoring the quality of client services provided and identifying areas of service improvement.

Gaps:

- Most providers that participated in the focus groups and interviews did not understand that this was an objective for the Documentation Project. The providers instead, expressed confusion as to why they are being asked to collect so many data elements when the state only needs a few of those. The project may have shared this objective early on in the project, however, we could not find evidence that it was communicated and re-enforced throughout the project. A project charter in combination with a structured communication plan can help re-enforce the importance of monitoring the client outcomes and provider service delivery.

Findings and Gaps (continued)

Critical Success Factor #3 – A Communication Strategy is defined and developed to match project requirements.

Findings:

- The First Steps program established communication guidelines and protocols for the Documentation Project. Evidence suggests that First Steps staff used a multitude of existing communication channels to communicate information and status including: Public Health Nursing Directors, First Steps State Team, First Steps Coordinators, First Steps Listserv, First Steps website for forms, First Steps Email Message Box, First Steps newsletter, Provider Advisory Group (PAG), First Steps Community Provider Groups, and Community Services Offices.
  - The communication protocol directs that any information be sent first or simultaneously to the Public Health Nursing Directors through Catalyst before being released to others.
  - The First Steps agency coordinators were used as a first line of communications. Their role in the program is to disseminate information from headquarters to the line staff level.
    - Regardless of the channels employed, First Steps providers overwhelmingly did not believe communication was sufficient to prepare them for implementation.
- Coordination of communication between the First Steps state team and the providers wasn't always consistent. For example, state management sent providers information indicating some data elements were voluntary without informing the state team of the change in requirements. This appeared to have impacted the credibility of the state staff with the providers. Providers expressed confusion when they received inconsistent and conflicting information from the state team.
- Providers believe the most useful communication is when it was distributed frequently and timely through work sessions, conference calls, emails, newsletter updates, and when networking through existing meetings such as the Statewide Coordinator's meetings. At one time, the state hosted statewide or regional meetings and work sessions and covered travel expenses for providers to participate.
- It became obvious within the focus groups that communications were inconsistently distributed within the agencies. Staff reported that communication was very good in some agencies, especially those with good electronic systems or those who had a skilled, trained and available coordinator. The process used to disseminate information assumes that a coordinator can determine the needs of the line staff, which may not always be the case. Staff had varying levels of awareness about program information.

Findings and Gaps (continued)

Critical Success Factor #3 – A Communication Strategy is defined and developed to match project requirements. (continued)

Gaps (from previous page):

- Effective communication results from a cycle of sending information out and receiving verification of receipt and understanding. Each completed cycle provides opportunities to adjust communication to the needs of the audience. The project sent communications to the providers, but lacked a validation process to ensure the communications were received and understood. The Documentation Project would have benefited from a formal feedback process or method to ensure materials reached the right people, at the right time. For example, the project could have used a roundtable approach, where random providers are invited to a working session or a teleconference call, throughout the project, to participate in focused discussion around information and communication distribution, the value of the information and any suggested modifications to communicate. These provide "touch points" within the project to gauge provider community understanding and readiness for the identified change.

Findings and Gaps (continued)

Critical Success Factor #4 – Training is tailored to the project outcomes and expectations.

Findings:

- Training for the new forms was offered by the Department, however, it was not required. To encourage provider participation, the First Steps state team attended almost every county provider meeting to provide training information and assistance regarding the new requirements. In addition, the First Steps state team contacted First Steps staff in every county via email and phone to provide information and support. And finally, training announcements and information on the new forms were posted on the First Steps website and newsletter.
  - Despite these attempts, not all providers were aware of the training opportunities or took advantage of the training offerings and assistance.
- Providers taking advantage of the training opportunities reported that it was helpful. During focus group sessions, state staff observing noted many times that the information shared about how and when to include specific forms was incorrect. This raises a concern that providers may not be using the forms correctly, which could negate the efforts to standardize practice. Almost without exception, providers believe that training should be more formalized for changes of this nature, and should be required.

  Gaps:

  - Sweeping changes such as those brought about during the Documentation Project need formalized training. There is a certain tension that exists between the providers and the state that make these decisions difficult and potentially unpopular. Training is frequently the first thing cut in any budget reduction exercise and it becomes increasingly more difficult to find money to pay for related travel and training materials. Yet, the lack of training can undo a program redesign. We believe training of some form should be mandated for changes as broad as those contained in the Documentation Project. Many organizations are not able to train 100% of the line staff, but a comprehensive train-the-trainers series ensuring that all providers have an least one representative available is more effective than leaving the training decision at the provider level. It will always be difficult for some providers to get needed training.
  - A formal training plan defining the goals and objectives, training materials, a schedule, intended participants, and a training assessment is needed to communicate the impact of the change and prepare staff to implement the change successfully.
    - As part of critical success factor #1, a project should always define the resources required to successfully implement the project. Training related costs should be a explicitly defined in the beginning and requested as part of the whole funding packet.

Findings and Gaps (continued)

Critical Success Factor #5 – The need for a pilot is calibrated against the extent of changes identified.

Findings:

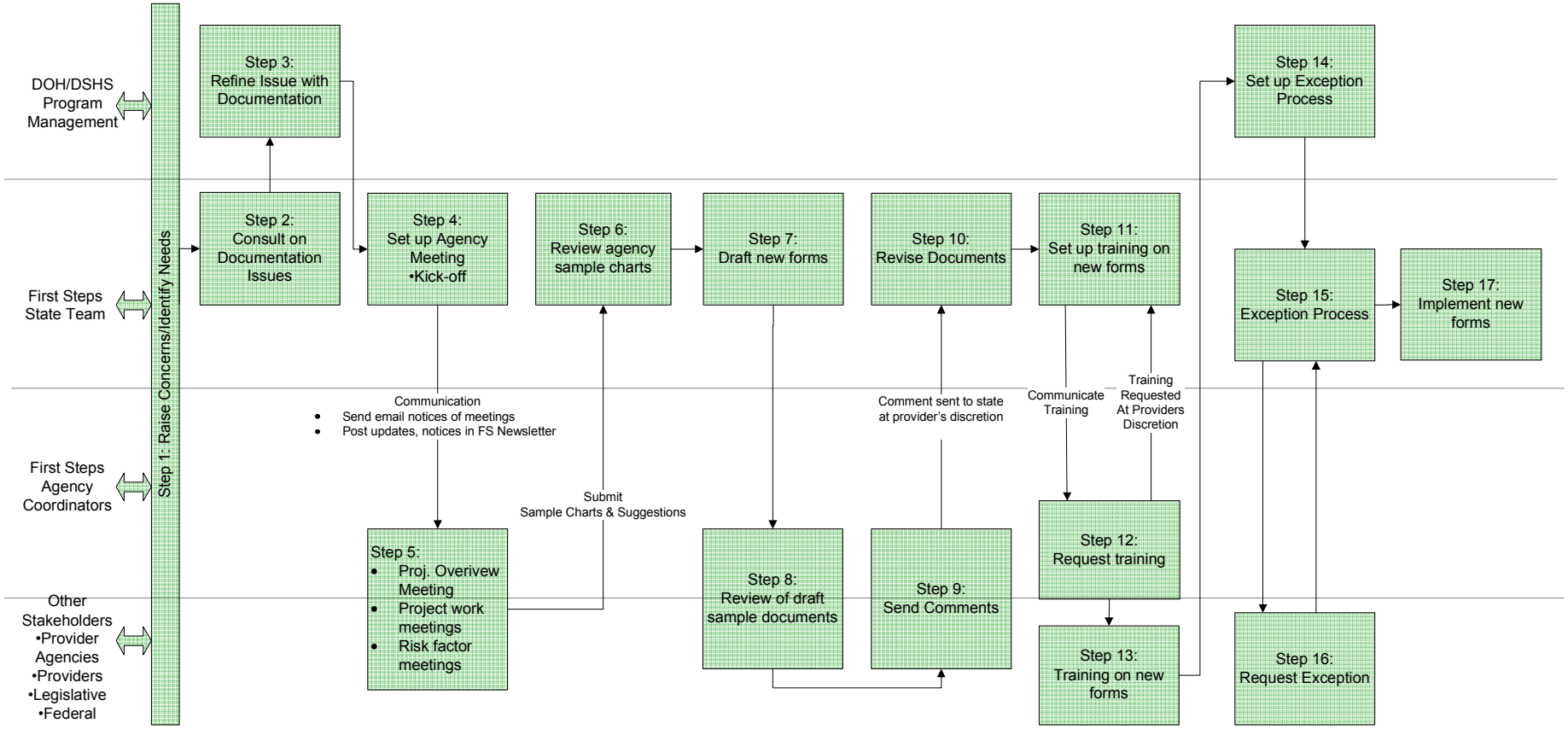
– Providers believe that a formal pilot period would have allowed a more robust review period for a small number of users to test the forms prior to full implementation. There remains some confusion regarding whether a pilot was used or not. A traditional pilot process generally includes a sub-set of users and a short duration of time. At the end of the pilot period, a formal assessment is completed and revisions to the process or forms are made as appropriate. Early project notes indicate DOH had considered a pilot, but there was no further evidence that a pilot had been implemented. DOH may have considered the provider review and feedback period of the draft forms as a pilot. However, this would not have met the requirements of a traditional pilot as described above.

Gap:

- A pilot would provide the Department with an opportunity to see, on a small scale, the forms in action and revise them prior to full implementation. In addition, pilots provide an opportunity to determine the impact on providers in more detail. Formal pilots require all the components of a formal project to ensure successful implementation. More specifically:
  - A project plan is developed and followed,
  - Key pilot participants are identified,
  - There is a specific start and finish timeframe,
  - Frequent work sessions are scheduled to discuss implementation and corrections, and
  - A formal recommendation is made to the management for the full implementation based on the pilot results.

First Steps – MSS/ICM Charting and Documentation Project "CURRENT" Workflow

This page represents a visual display of Sterling Associates' understanding of the "CURRENT" work flow process used to implement the MSS/ICM Charting and Documentation Project. Information to develop this view was gathered through interviews, focus groups, correspondence and research on the First Steps website. This EXHIBIT 2 displays a comprehensive view of the "CURRENT" process. We have provided a detailed view of tasks under each step in the supporting APPENDIX A.



Continuous Quality Improvement (CQI) Model "TO BE"

The significance of the proposed CQI model is that it is patterned with refinements based upon the existing Documentation Project model used by DOH. The recommended CQI model shown on pages 37 to 52 displays the "To Be" process steps within the CQI model, highlighting key activities within each step. To effectively use the model, the processes must all be assessed in relation to the project goals for their relevancy and value. However, there are key process steps that should exist for all projects such as a project plan, timeline, roles and responsibilities and a communication strategy. Depending on the size and complexity of change, all steps may be needed.

What is CQI?

- Continuous Quality Improvement is a strategic approach to improve products, services or processes. It is an on-going effort to seek continuous, incremental improvement over time. Key elements of CQI include plan for improvement or change, do and measure the impact of change, and check the benefits of the change and act to expand a boarder implementation.

What's in CQI?

- Planning for improvement or change (PLAN),
- Implementing the change on a small scale (DO),
- Measuring the impact of change (CHECK), and
- Expanding to a broader implementation (ACT).

Value of CQI!

- Reduces rework by having the right information,
- Reduces errors by correcting the process,
- Increases performance by focusing on the results,
- Increases awareness by communicating continuously with employees and stakeholders, and
- Improves customer service by eliminating or correcting unnecessary actions or processes.

Continuous Quality Improvement Model

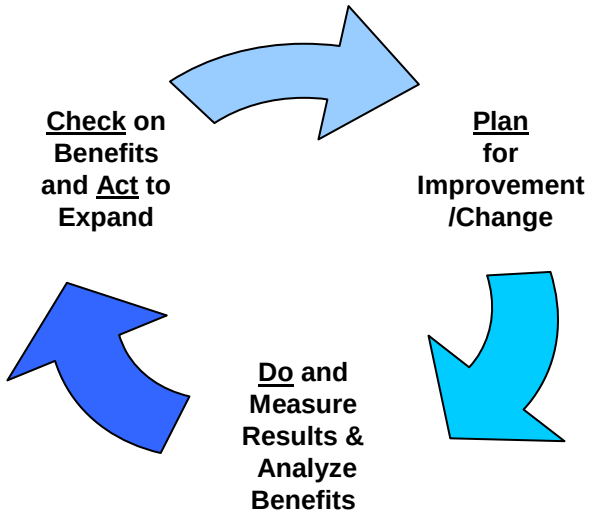
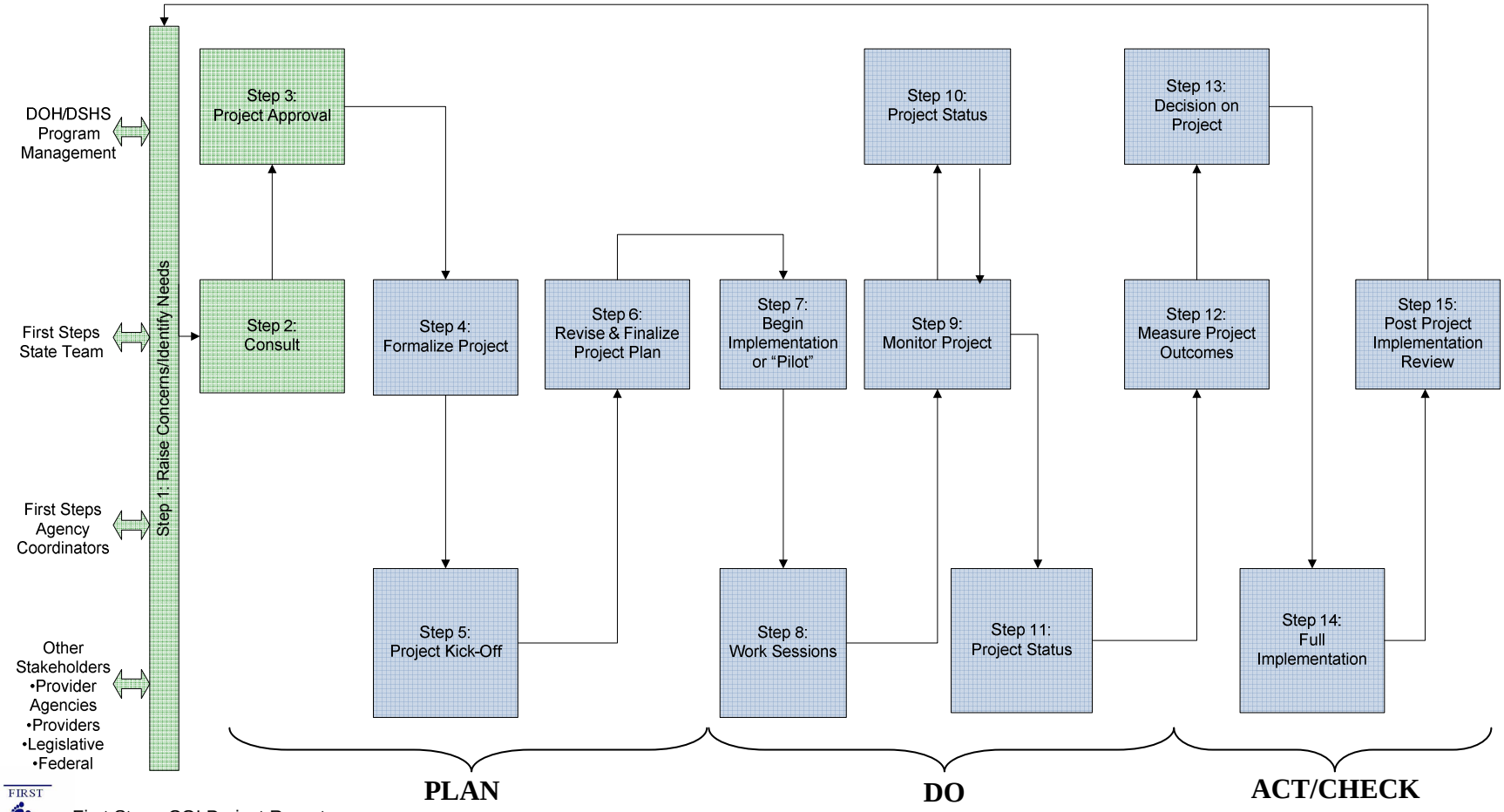


Exhibit 3

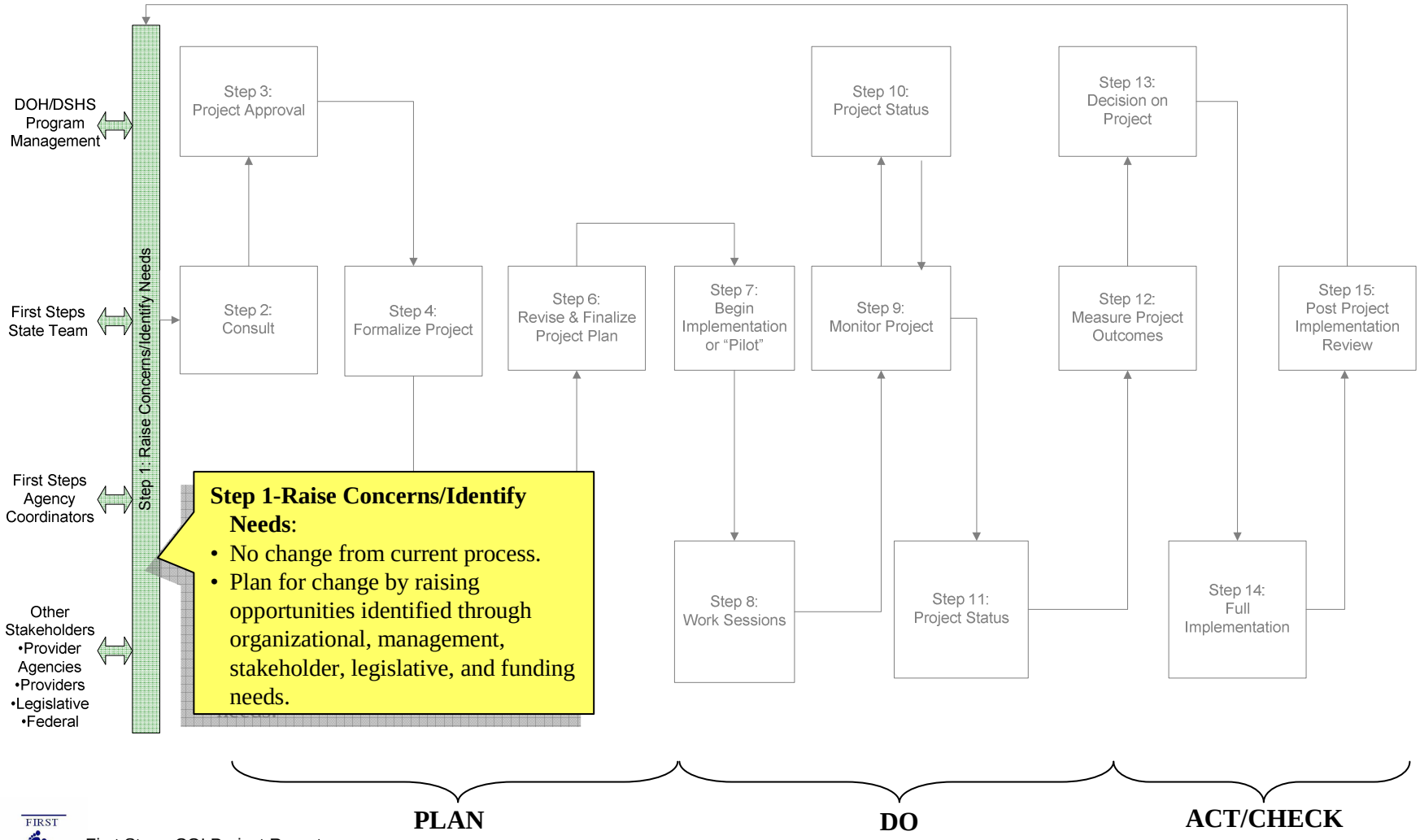
Continuous Quality Improvement Model (CQI) – "To Be" Workflow Process

Recommended CQI Model – Exhibit 4 below depicts the recommended "to-be" process workflow. The green workflow boxes represent processes that remain the same as those identified in the "current" process, while the blue boxes represent suggested changes and refinements to the workflow process. Subsequent pages will include detailed actions to take during each step of the process.



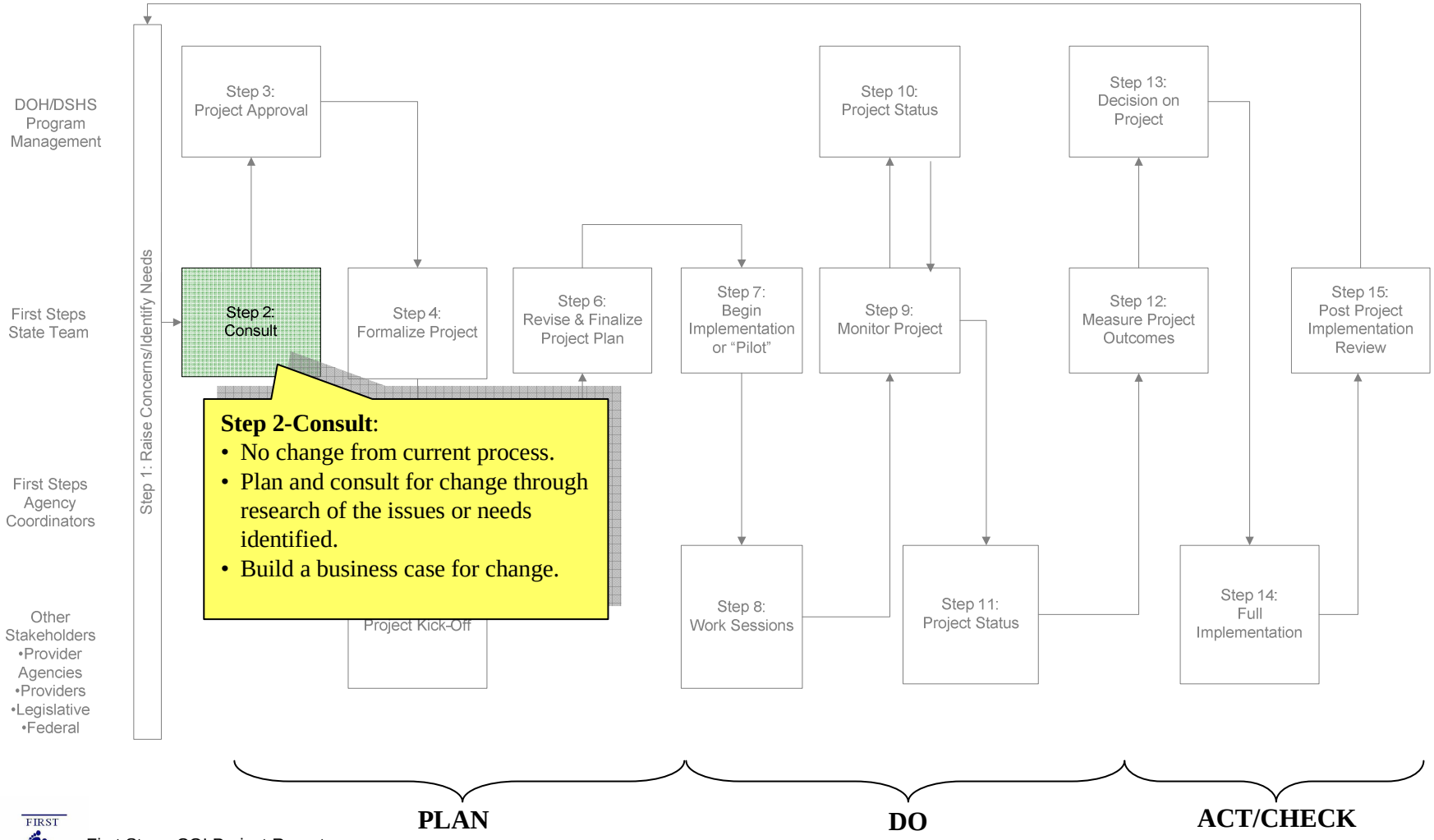
Continuous Quality Improvement Model (CQI) – "To Be" Workflow Process

Recommended CQI Model – Step 1: Raise Concerns/Identify Needs



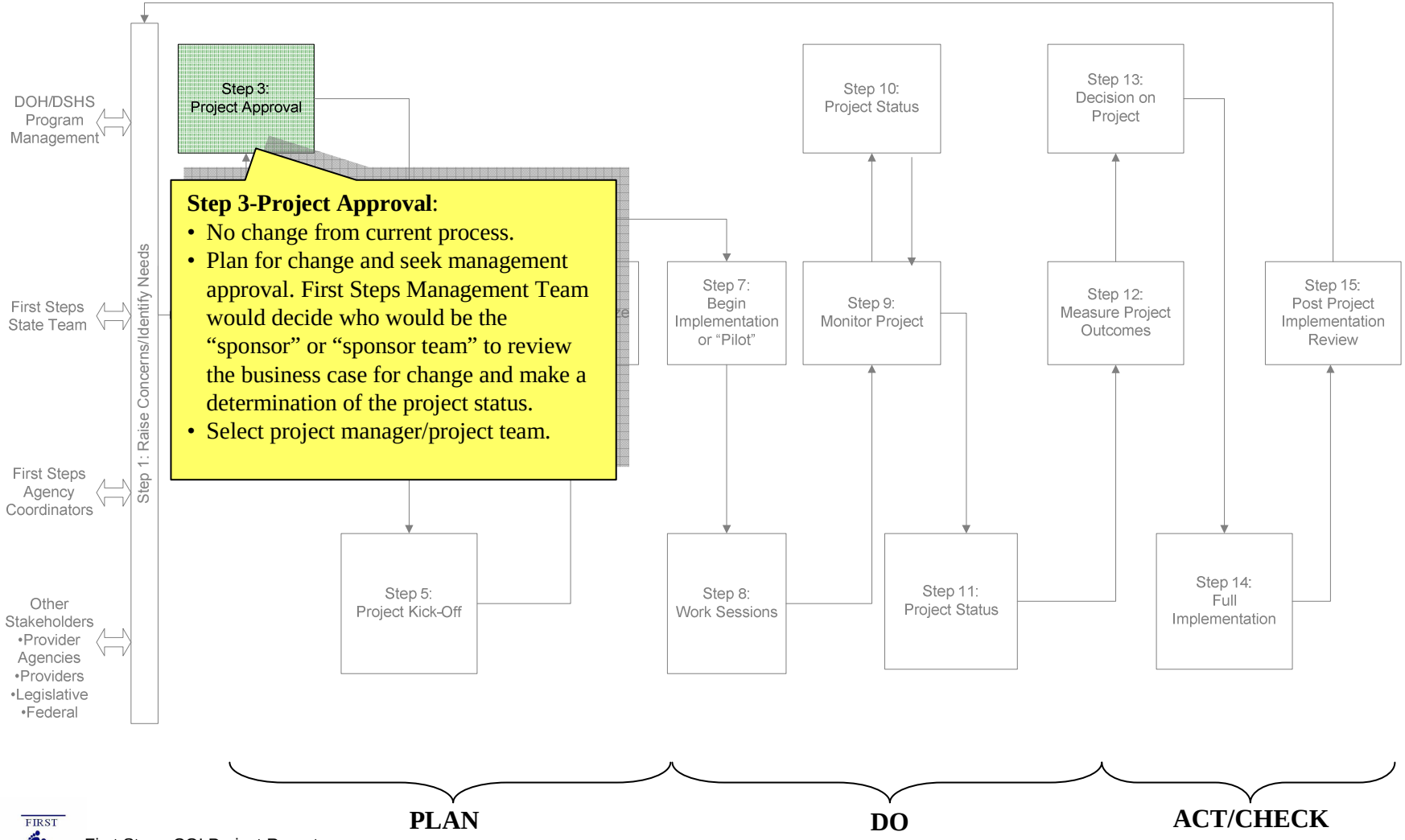
Continuous Quality Improvement Model (CQI) – "To Be" Workflow Process

Recommended CQI Model – Step 2: Consult



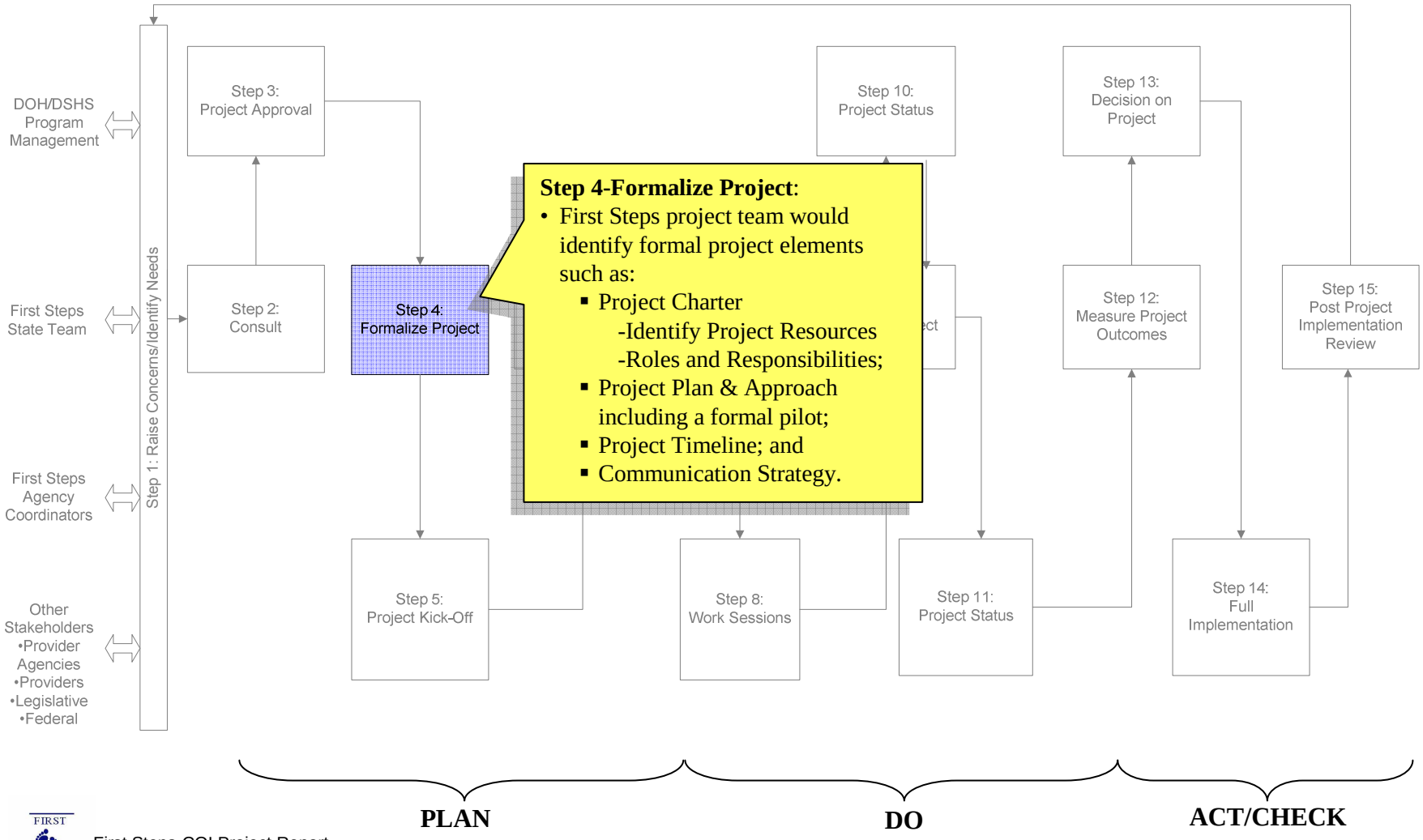
Continuous Quality Improvement Model (CQI) – "To Be" Workflow Process

Recommended CQI Model – Step 3: Project Approval



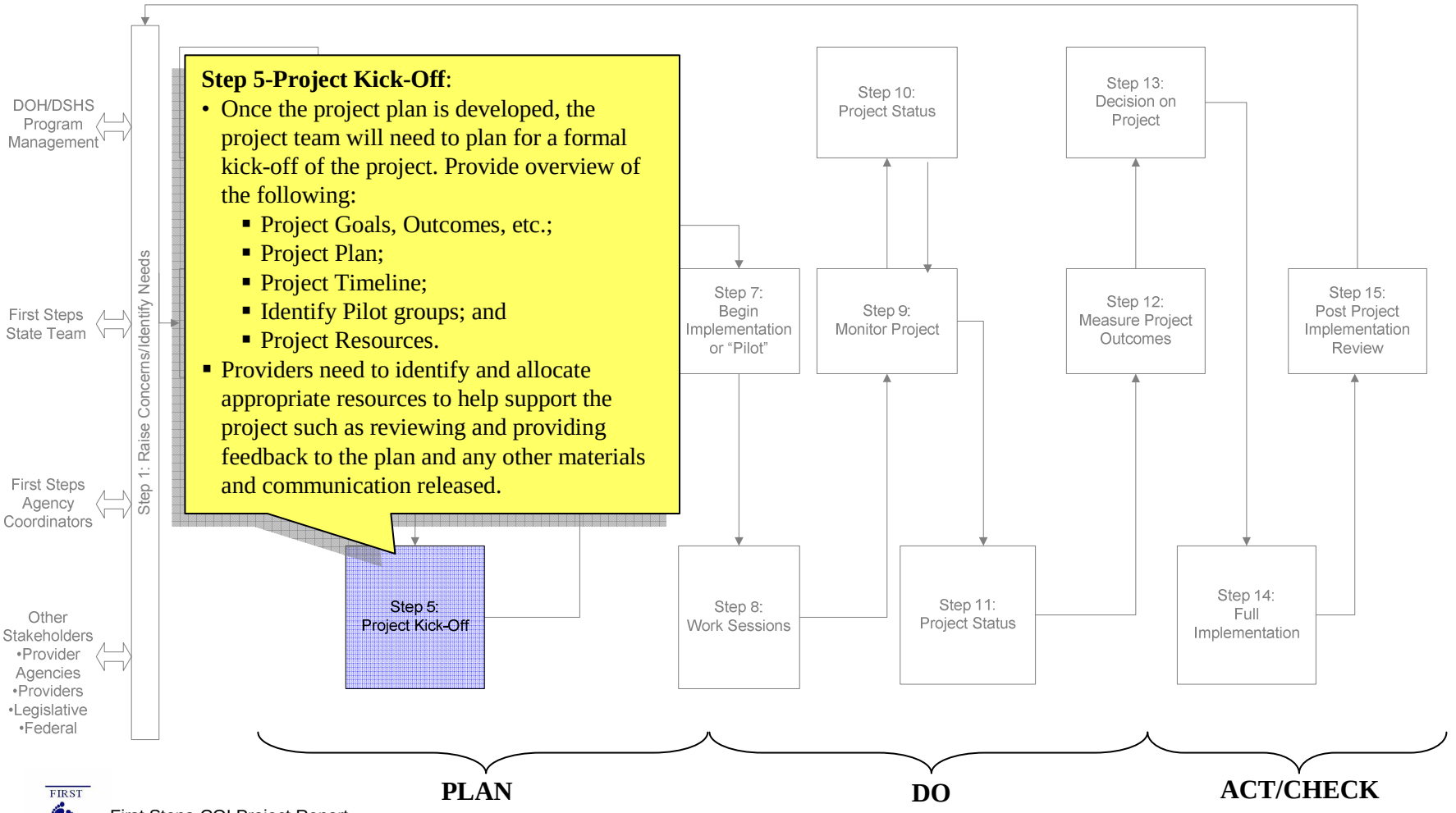
Continuous Quality Improvement Model (CQI) – "To Be" Workflow Process

Recommended CQI Model – Step 4: Formalize Project



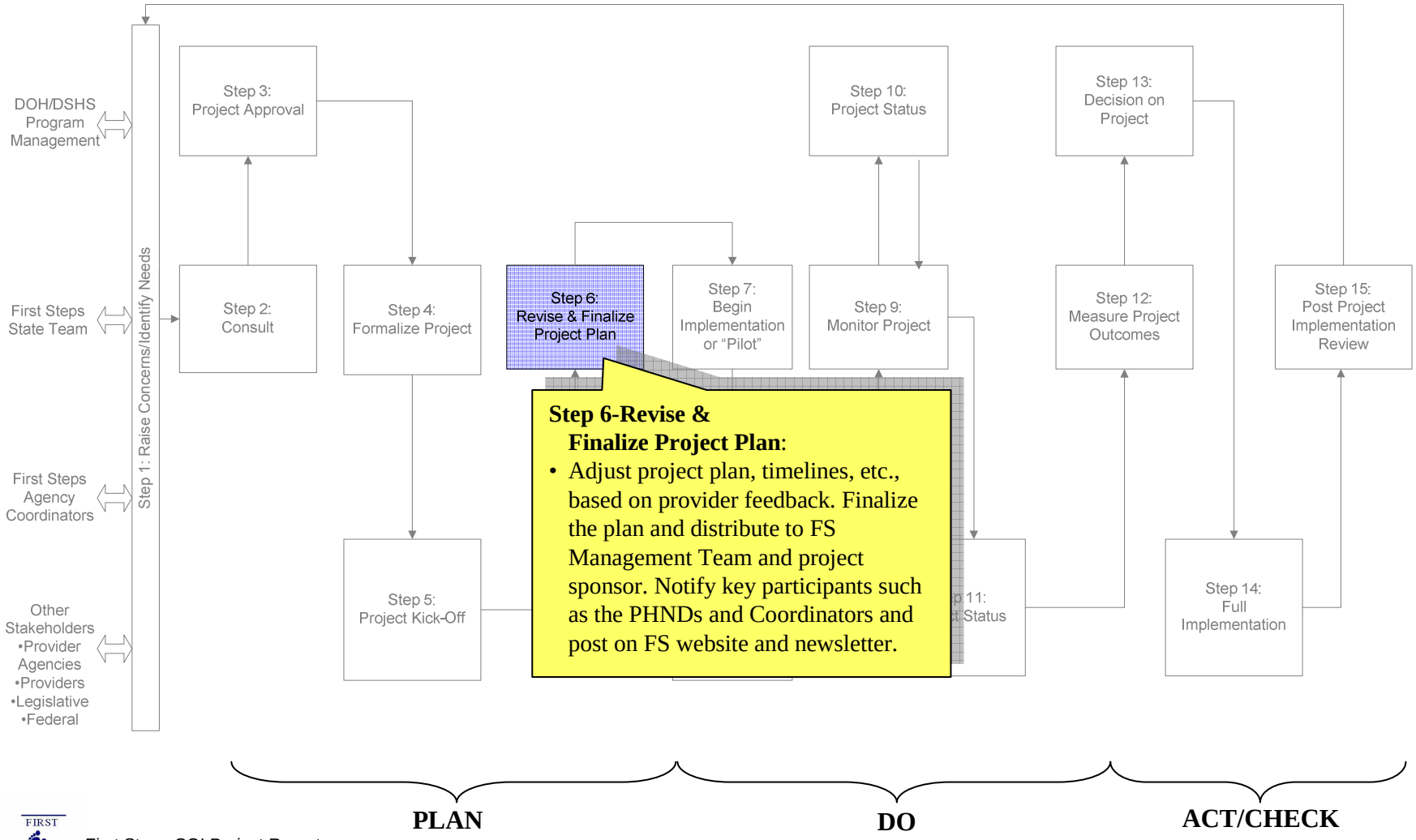
Continuous Quality Improvement Model (CQI) – "To Be" Workflow Process

Recommended CQI Model – Step 5: Project Kick-Off



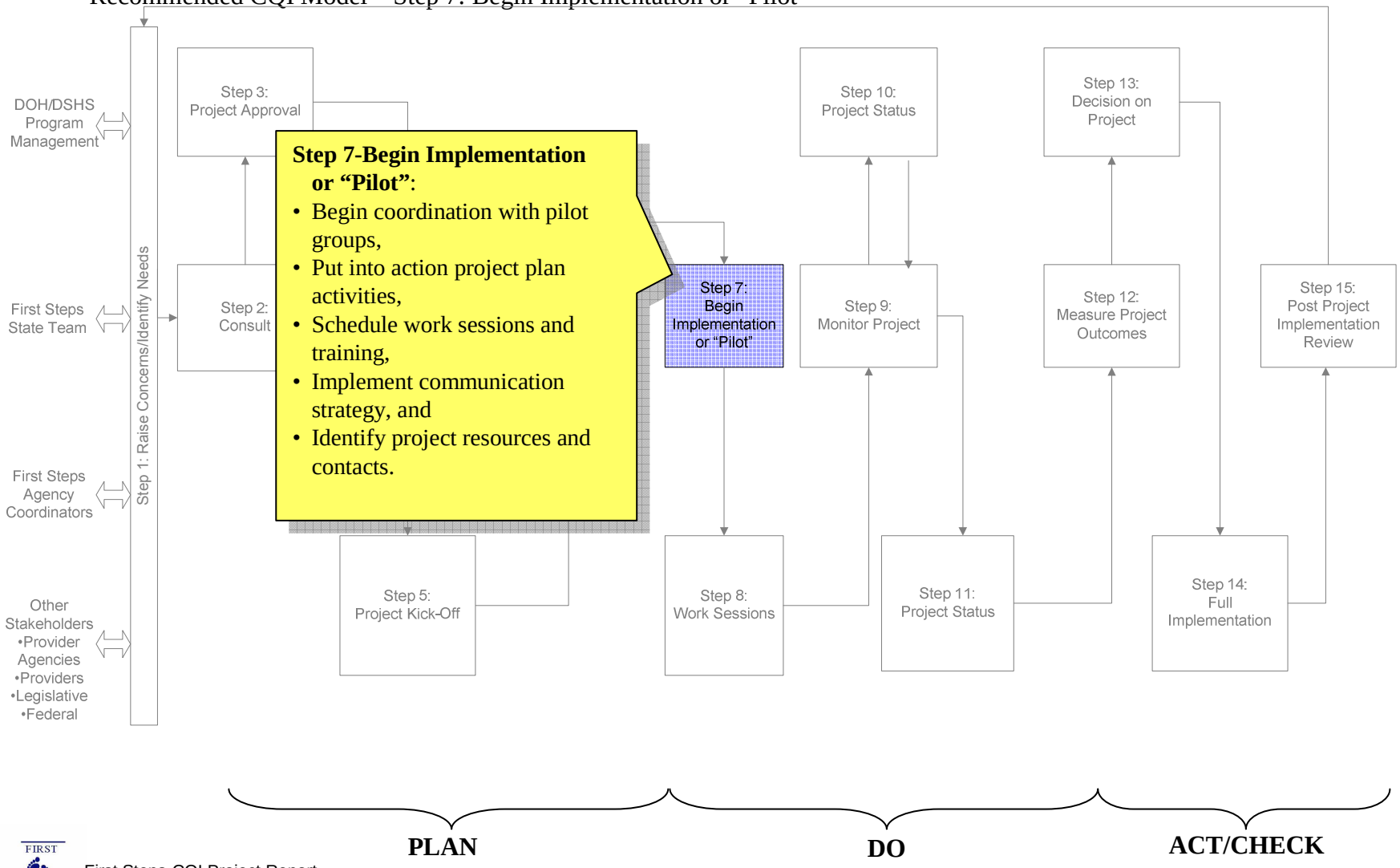
Continuous Quality Improvement Model (CQI) – "To Be" Workflow Process

Recommended CQI Model – Step 6: Revise and Finalize Project Plan



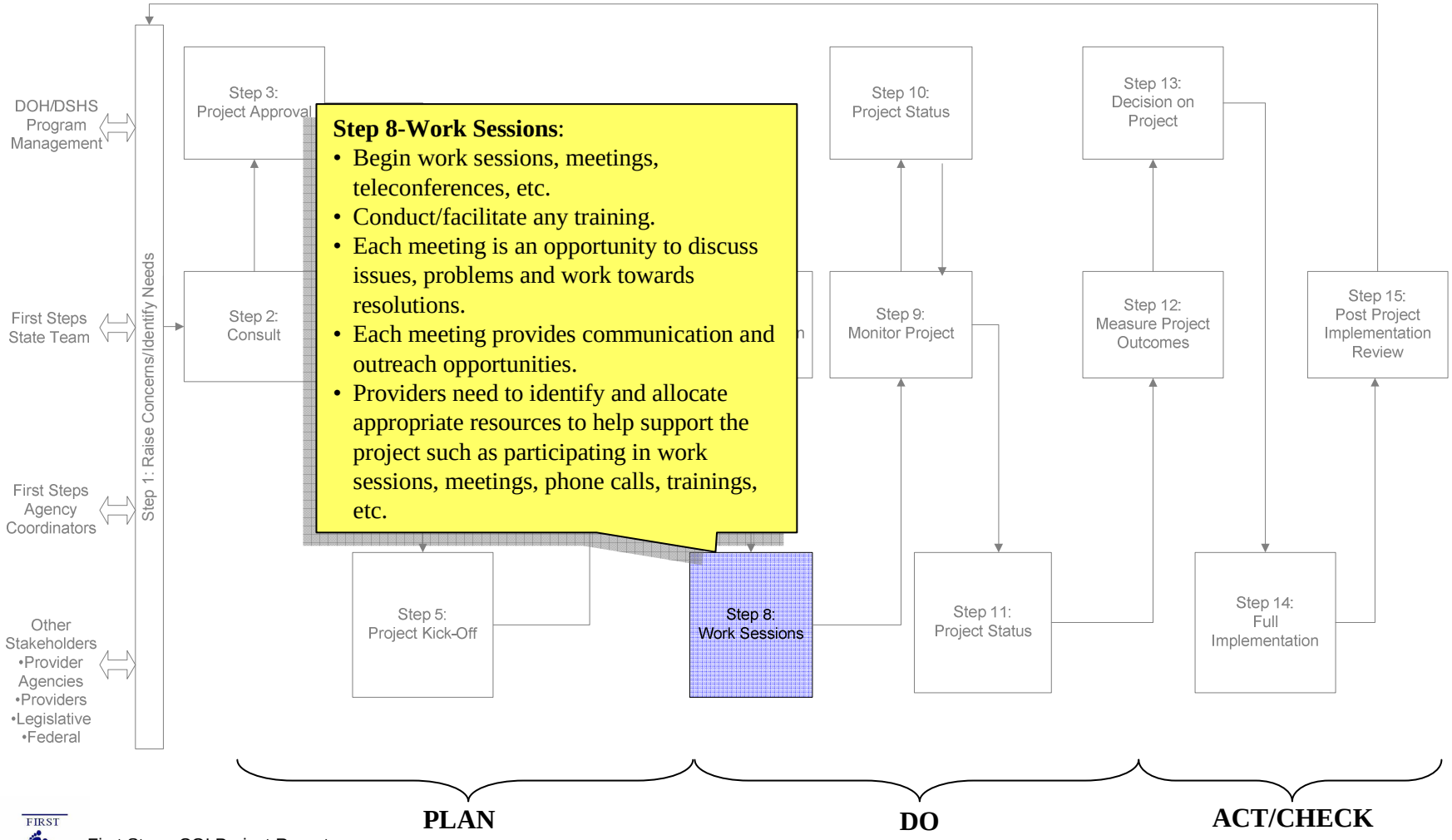
Continuous Quality Improvement Model (CQI) – "To Be" Workflow Process

Recommended CQI Model – Step 7: Begin Implementation or "Pilot"



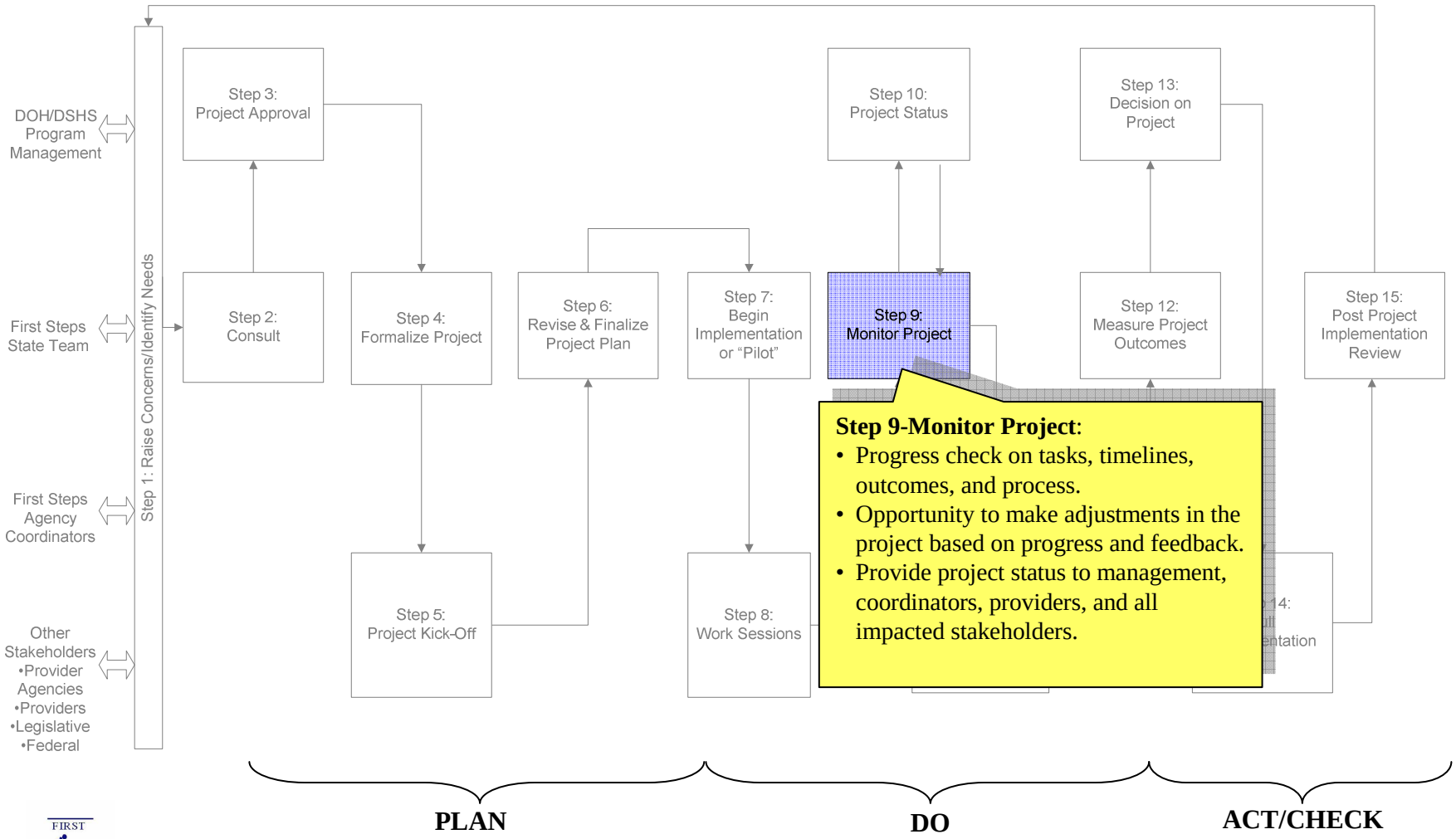
Continuous Quality Improvement Model (CQI) – "To Be" Workflow Process

Recommended CQI Model – Step 8: Work Sessions



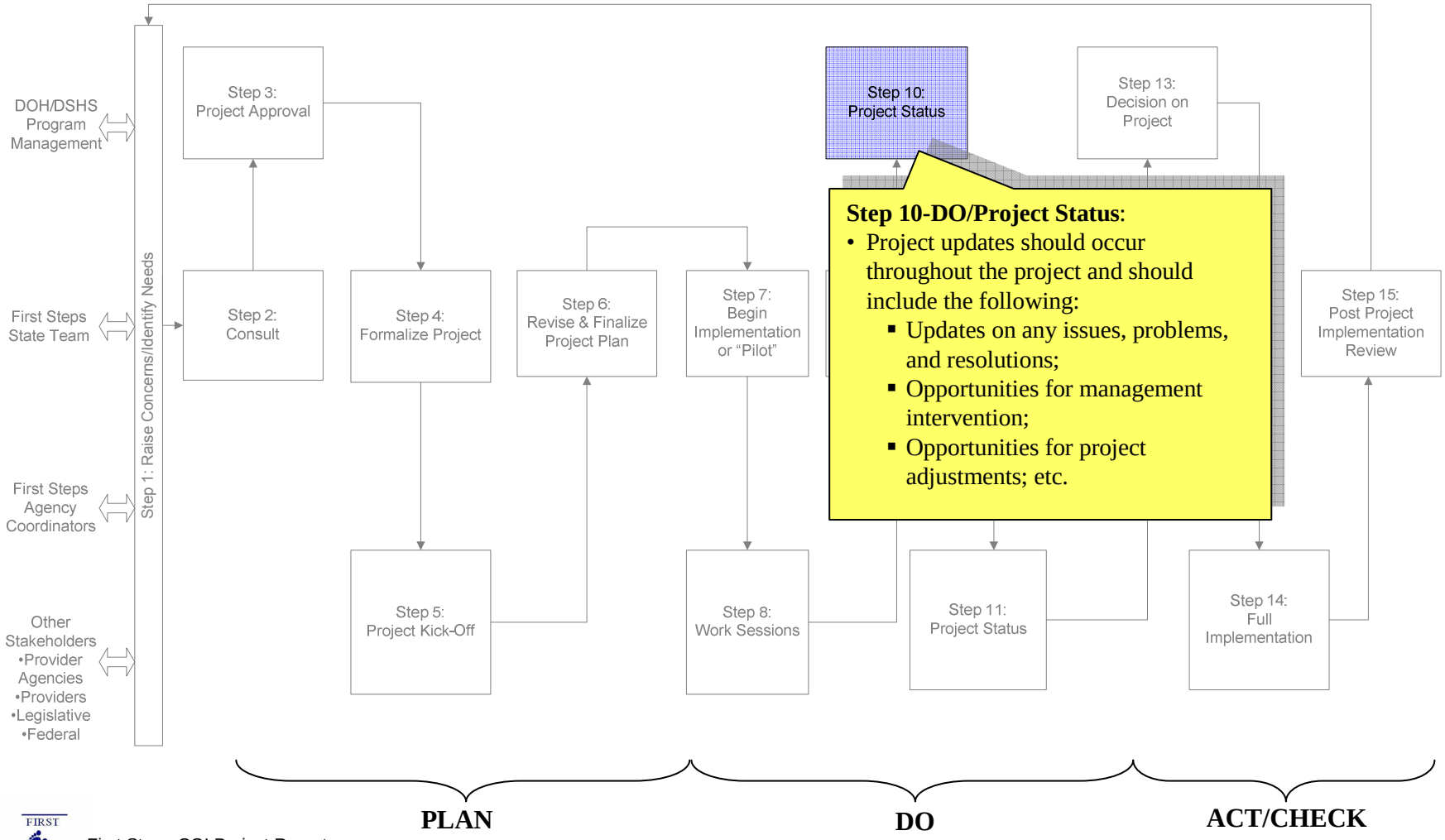
Continuous Quality Improvement Model (CQI) – "To Be" Workflow Process

Recommended CQI Model – Step 9: Monitor Project



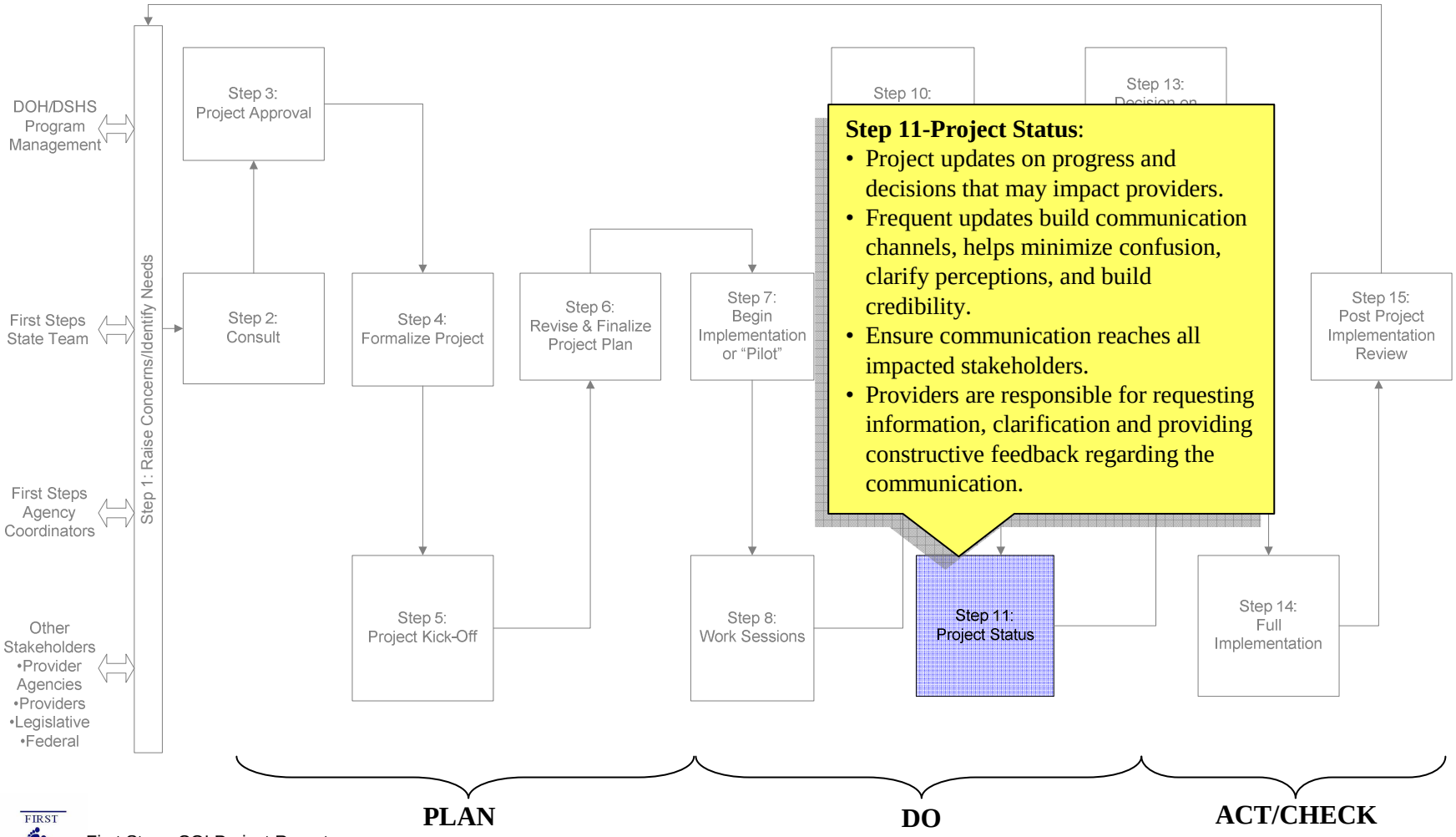
Continuous Quality Improvement Model (CQI) – "To Be" Workflow Process

Recommended CQI Model – Step 10: Project Status



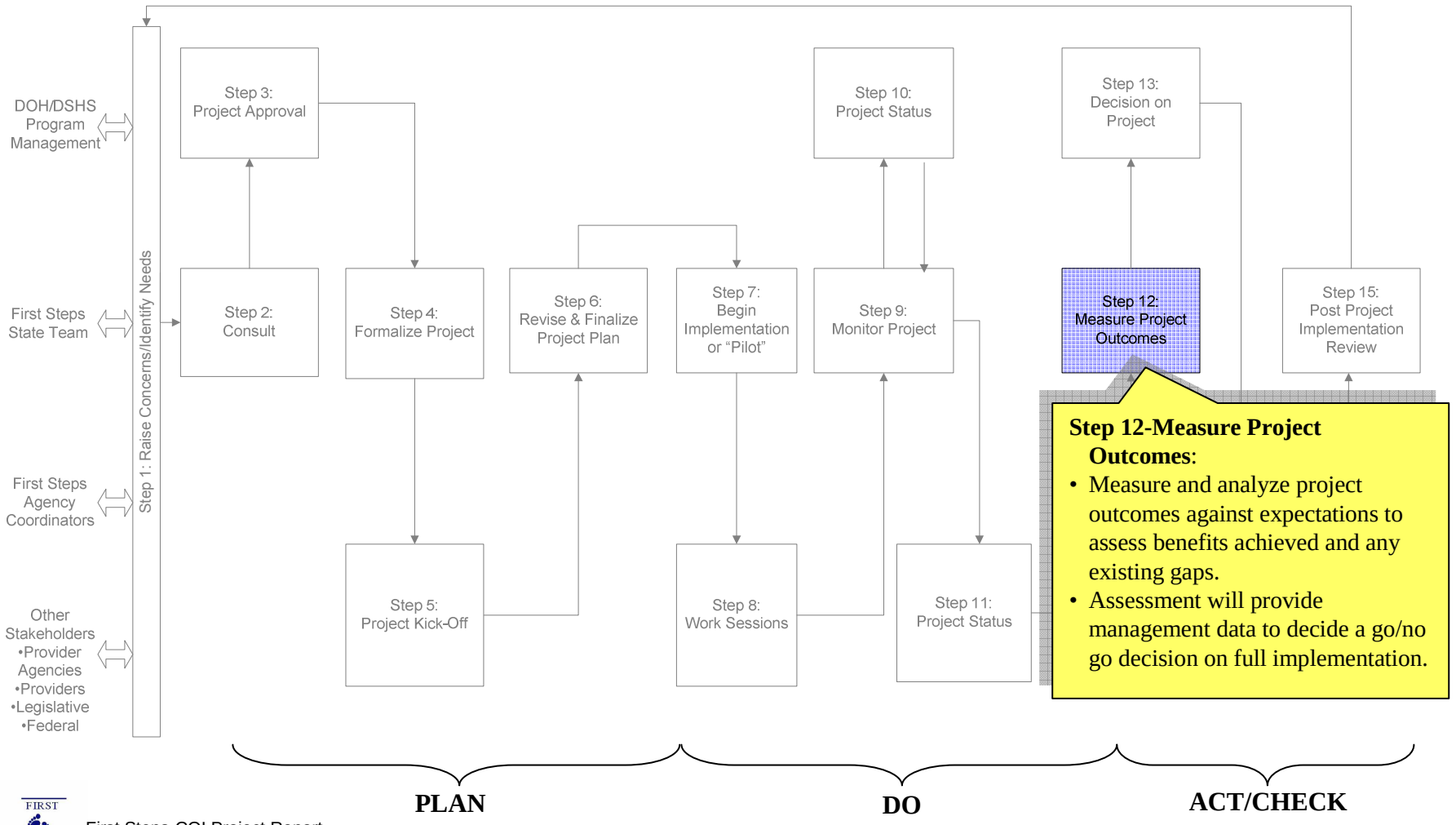
Continuous Quality Improvement Model (CQI) – "To Be" Workflow Process

Recommended CQI Model – Step 11: Project Status



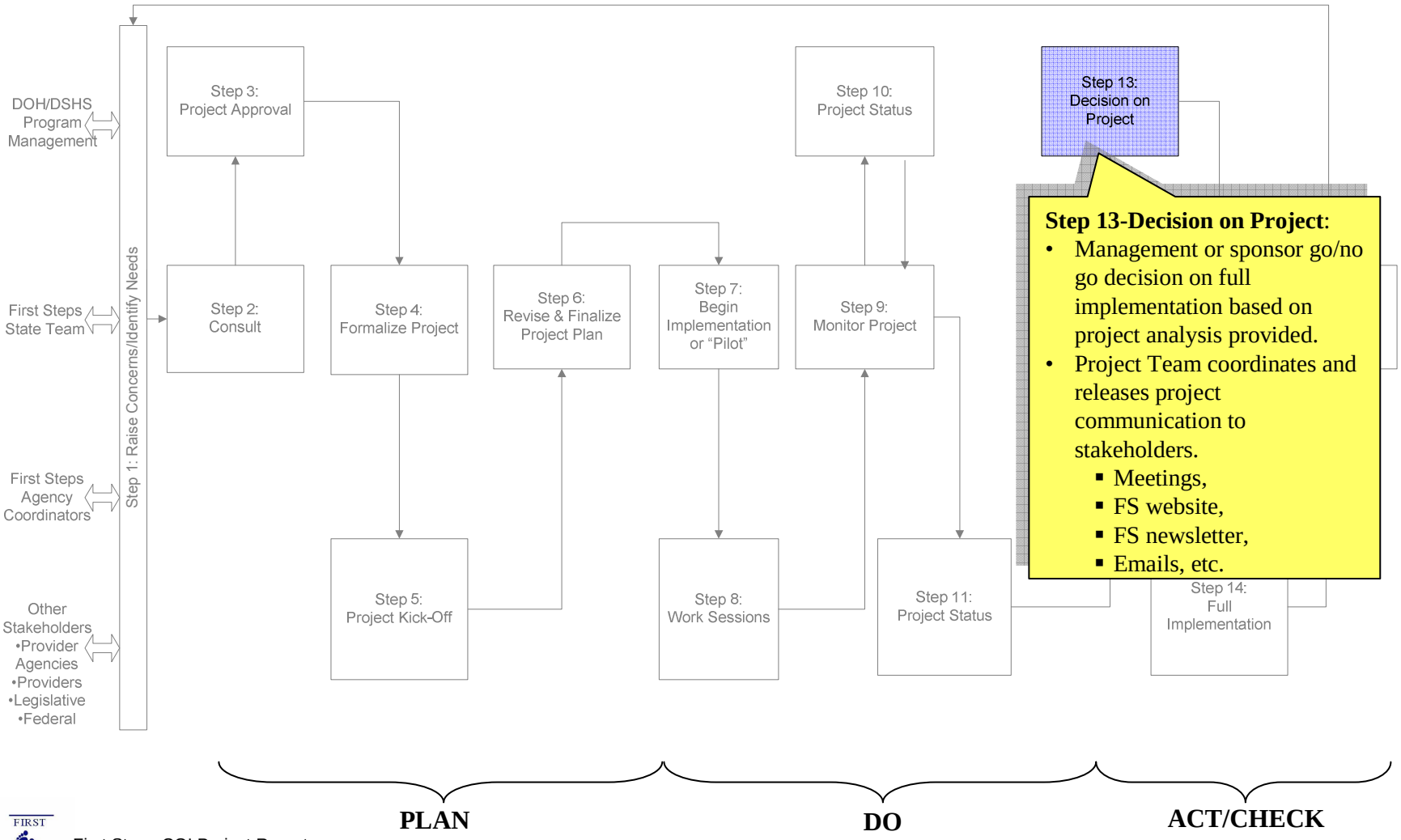
Continuous Quality Improvement Model (CQI) – "To Be" Workflow Process

Recommended CQI Model – Step 12: Measure Project Outcomes



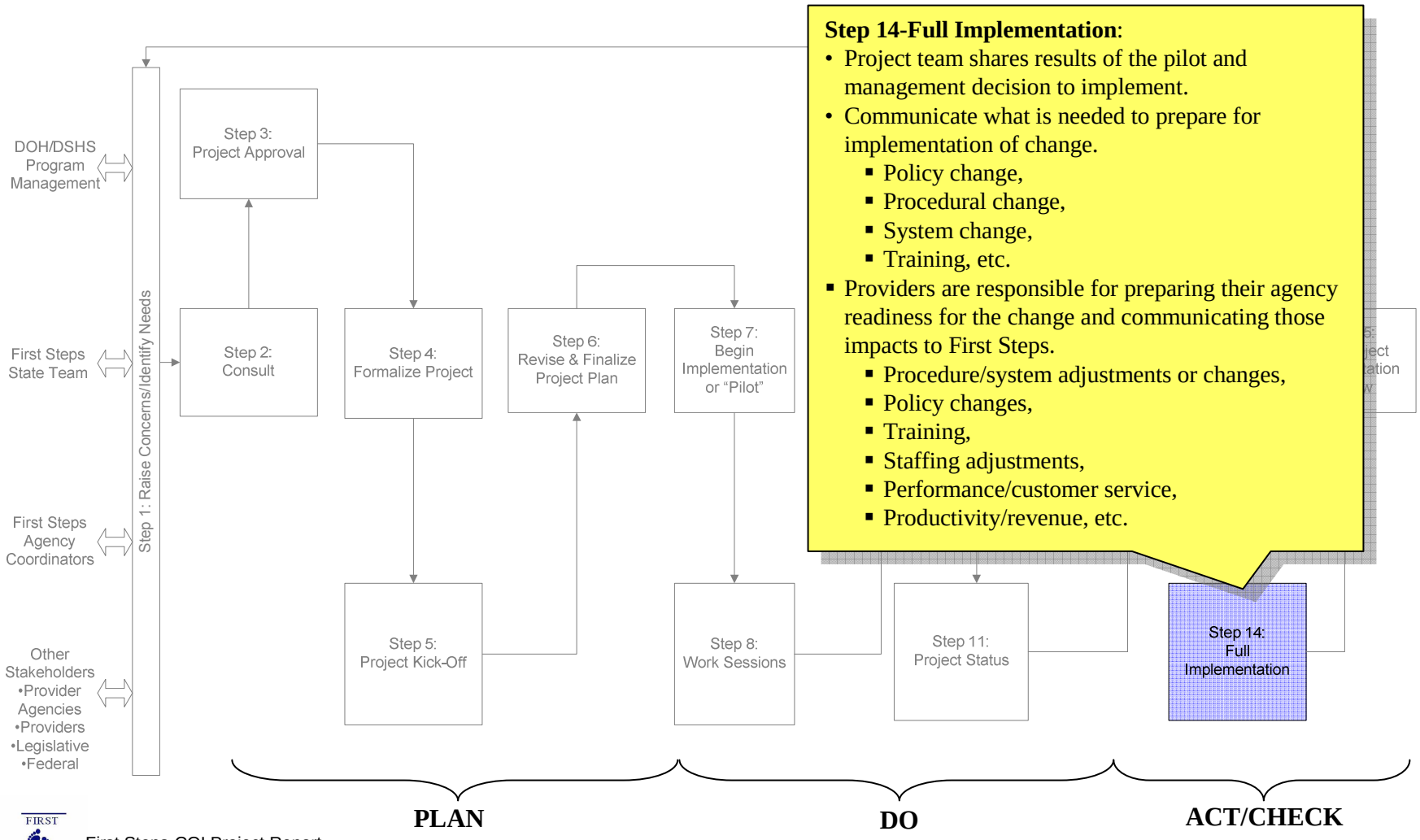
Continuous Quality Improvement Model (CQI) – "To Be" Workflow Process

Recommended CQI Model – Step 13: Decision on Project



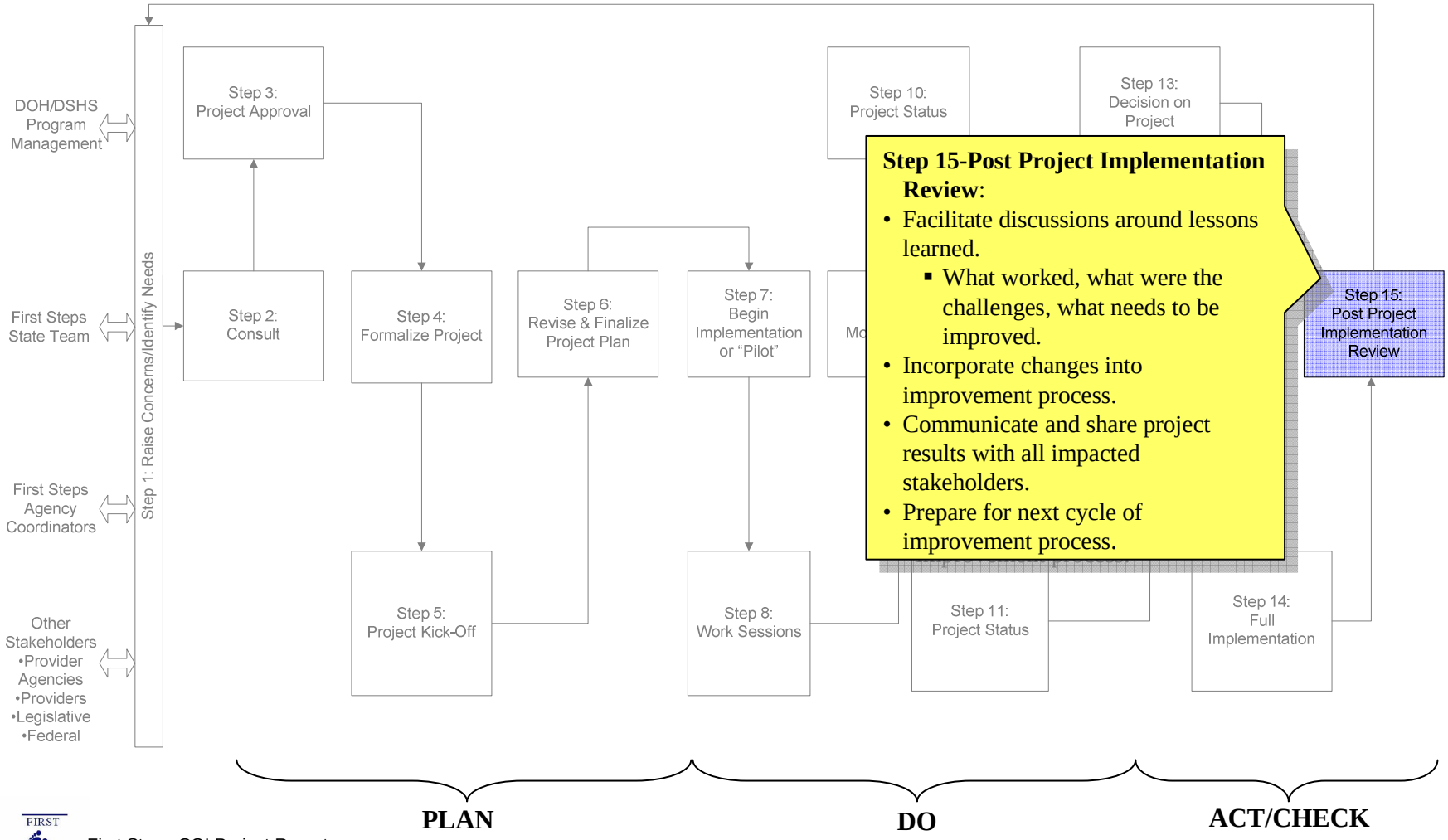
Continuous Quality Improvement Model (CQI) – "To Be" Workflow Process

Recommended CQI Model – Step 14: Full Implementation



Continuous Quality Improvement Model (CQI) – "To Be" Workflow Process

Recommended CQI Model – Step 15: Post Project Implementation Review



Communication Plan

Successful projects rely on effective communication that is relevant, timely and reaches the right audience. Developing a communication strategy is an integral part of project planning and can be one of the most difficult elements of a project to manage. It can drive perceptions and due dates, and create challenges and risks if not properly managed. The communication model below contains the four key elements that must always exist in a communication strategy to be effective; information to be shared, who it is shared with, the frequency of distribution, and the method for delivery. The specific components within each element will vary from project to project and are dependent on the scope, size and duration of the project and the sweeping impact of the change. This model is designed to provide an outline to assist in developing a communication strategy. It is intended to be used like a menu to select and refine each component based on the needs of the project team, management and stakeholders.

Information	Audience	Frequency	Method
Project Announcement	•Management •Participants •Impacted Stakeholders	•Beginning of Project •Beginning of Project •After Project Kick-Off	•Meetings •Project Kick-Off •Website, newsletter, email (listserv)
Project Documents	•Management •Participants	•Draft Format •Draft Format	•Meeting •Work Session
	•Management •Participants	•Final Format •Final Format	•Email •Mail, email (listserv), website
Project Status	•Management •Participants •Impacted Stakeholders	•Dependent on project timeline (weekly, monthly)	•Meetings & Reports •Teleconference •Website, newsletter, email (listserv)
Project Outcomes	•Participants	•Beginning of project to share what the expected outcomes are •At evaluation of the outcomes, mid-project •At end of the project as a project summary •Post project implementation for longer/residual benefits achieved	•Kick-Off •Meeting •Report •Report
	•Management	•At evaluation of the outcomes, mid-project •At end of the project as a project summary •Post project implementation for longer/residual benefits achieved	•Meeting •Meeting & Report •Report
	•Impacted Stakeholders	•At end of the project as a project summary	•Report

Improvement Opportunities

Providers participating in the CQI focus groups and interviews were asked to identify and prioritize key challenges as well as solutions related to the Documentation Project and the First Steps program. These challenges and suggested solutions were identified by Sterling Associates' as potential improvement opportunities for consideration by the state based on several criteria.

- Did the challenge/solution represent the majority of providers feedback from the focus groups and interviews?
- Will the challenge/solution provide a level of return on benefits for the providers and state based on the investment made?
- Can the challenge/solution be addressed and supported with resources by the state?
- Can the challenge/solution incorporate process steps from the proposed CQI model?

The following are three improvement opportunities that providers considered to be their highest priority.

Networking Opportunities: Providers would like to see First Steps program host Regional Coordinators Meetings and Statewide Meetings. Providers found value within these meetings for the following reasons:

- Opportunity for training and receiving industry updates,
- Forum to receive information uniformly and consistently,
- Ability to network with peers and state team, and
- Opportunity to share best practices regarding issues, problems, and or processes.

Training Plan: Providers would like a Training Plan. They would like First Steps to explore multiple methods of training including in-person, video conferencing, web-base, DVD, etc. Providers expressed interest in receiving training but need to have advanced notification to coordinate their schedules. To this end, they would like to see an annual training plan and calendar posted.

Forms Improvement: Providers expressed frustration with many of the new forms and would like to see a number of the forms improved. We believe choosing one form for improvement would allow the state to test the CQI model and at the same time, engage the providers in small, incremental steps.

Next Steps

- Review, refine, and adopt a continuous quality improvement model.
- Identify dedicated resources to manage and support on-going improvement efforts.
  - Ensures project planning,
  - Ensures coordination of project tasks and communication,
  - Monitors project progress and reports status,
  - Analyzes project results against project goals, and
  - Provides information and guidance for executive management decision regarding the outcomes.
- Communicate First Steps plan of action regarding continuous quality improvement with the providers.
  - Identify and plan for the next improvement opportunity and communicate the project information to providers.
    - Reason for the improvement,
    - Project/work plan with timeline, and
    - Project resources (who is involved).
- Conduct post implementation review of project.
  - Assess project processes, and
  - Evaluate the CQI model.